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ABSTRACT

The American Indian Rehabilitation Project aimed to provide older American Indians with vision problems useful skills for carrying out daily activities as independently as possible and for preventing unnecessary dependence on others and premature and unwarranted institutionalization. The project goals were to: (1) develop a 5-day, seven-module model curriculum for training community health representatives (CHRs); (2) train approximately 200 CHRs representing various tribes at 5 training sessions; (3) evaluate the training sessions by assessing the extent to which CHRs were utilizing the information and skills learned; and (4) disseminate training results and the model curriculum to the blindness, aging, and Native American service delivery systems. A second phase aimed to expand training and evaluation. The methodology section of the report contains information on project staffing, resources, training materials and methods, and assessment instruments and surveys. The outcomes section indicates that the project's major objectives were fulfilled, and reviews findings related to: (1) CHRs' pretraining attitudes; (2) cultural issues of independence, interdependence, and psychosocial aspects of aging and vision loss; (3) cultural applications of new skills; (4) CHRs' strategies for sharing their learning; (5) culturally appropriate communication patterns and teaching methods; and (6) followup reports by CHRs on the personal and professional impact of the training. A project summary and recommendations are included. The 28 appendices include a training agenda; key words; various forms, assessments, and results; a followup interview of CHRs; and lists of resources. (KS)

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A Training Model to Teach Community Outreach Workers to Train Elderly Blind and Visually Impaired American Indians Independent Living Skills: Focus on Family Rehabilitation

Alberta L. Orr
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Final Report to the Administration on Aging
August 1990

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Chapter 1

INTRODUCTION

The Nature of the Problem: Aging and Vision Loss and American Indian Elders

American society is characterized as an "aging society" with people living longer and fuller lives past the retirement years. Aging is, however, accompanied by many health conditions and disabilities which are concomitants of the aging process. One condition is that of visual impairment, ranked among the top ten conditions which disable America's elderly (Blake, 1984). Minority populations experience a higher incidence of vision loss than the Caucasian population because of certain health conditions which lead to vision loss. One such condition is diabetes, and the eye disease associated with it--diabetic retinopathy. This is the case for American Indian elders. The following facts describe the American Indian elderly population with regard to vision loss:

- American Indian elders have a higher incidence of visual impairment than the general elderly populations.
- American Indian elders have less access to agencies for the blind and rehabilitation services because they are unaware that such services exist and that they are eligible for them.

- American Indian elders also have limited access to rehabilitation services because of language and cultural barriers.
- American Indian elders have the right to have equal access to rehabilitation services so that they may function as independently and as interdependently as possible within the tribal context.

The American Indian elderly population is growing rapidly, as is its elderly visually impaired population. If American Indian elders are not going to go to agencies for the blind, independent living skills training must be brought to them both on and off the reservations.

The American Foundation for the Blind (AFB) designed and implemented a training program to bring independent living skills training to American Indian elders through a project supported by the Administration on Aging (AoA). The project involved training a group of paraprofessionals who worked as community outreach/ health care service workers about aging and vision loss issues and adaptive techniques to accomplish activities of daily living.

Background

Visual Impairment in the Elderly Population

According to a projection made in 1979, between 1977 and the year 2000 the number of older persons with a severe visual impairment was expected to increase from 990,000 to 1,760,000 (Kirchner, 1985). Yet statistics gathered by the National Health

Interview Survey Supplement in Aging, conducted in 1984 and released in 1987 by the National Center for Health Statistics (NCHS), estimated that 2,038,000 elderly persons were severely visually impaired in the year the survey was conducted (Nelson, 1987). The year 2000, then, has already arrived, presenting the fields of blindness and aging, health care and family caregivers, with an unexpected number of older people needing a myriad of services due to varying degrees of vision loss.

The data also indicate that of every 1,000 elderly persons almost 78 are severely visually impaired, an increase of almost 74 percent over that estimated from the 1977 statistics.

The documented 2,038,000 severely visually impaired older persons represent 8 percent of the community-based elderly population. It is a safe estimate to say that there are somewhere between 3-4 million older visually impaired persons in the country representing at least 10 percent of the elderly population. This number is still thought to be an extremely conservative undercount because of the general difficulties of data collection, i.e. the wording of questions related to visual impairment and the hesitation of older persons to admit that they have trouble seeing. Among nursing home residents 3 percent have no vision at all, with another 26 percent partially sighted or severely visually impaired (having some usable remaining vision).

Sixty-six percent of older persons who are severely visually impaired in this country live in their own homes in their own communities with varying degrees of assistance and support

services from family members and other non-paid caregivers, as well as service providers. Sixty-six percent of older persons who are visually impaired also have at least one other chronically disabling condition, including arthritis, hypertension, arteriosclerosis and hearing impairment, which have the potential for inhibiting independent functioning and mobility (Blake, 1984).

Elderly persons representing minority groups including blacks, Hispanics and American Indians are more vulnerable to vision problems throughout their lives and have higher proportions of vision loss among their elderly than the Anglo elderly population.

The incidence of visual impairment among minority populations throughout the country is dramatically higher than the incidence among white Americans. Forty-two out of every 1,000 white elderly persons are severely visually impaired compared to 71 out of every 1,000 non-white elderly persons (American Foundation for the Blind, 1982). A look at the incidence of visual impairment among Native Americans points to their need for access to rehabilitation services.

Visual Impairment Among Native Americans

According to the National Indian Council on Aging (1986), the number of American Indians 60 years of age and over has increased dramatically with a 1970 census count of 64,000, 109,000 in 1980, and over 200,000 by 1990. The National Congress

of American Indians reported that the 200,000 projection for 1990 had already been reached in 1986, with the population of elderly American Indians continuing to increase dramatically. In 1980 life expectancy of the American Indian was 71.1 years, compared to 60 years in 1950 (Rhoades, E. R., D'Angelo, A. J. and Hurlburt, W. D., 1987). Impairment levels of Indians and Alaskan Natives 55 and older are comparable to non-Indian U. S. elderly 65 and older. Rural Indians and Alaskan Natives 45 and older are comparable to non-Indian elderly 65 and older (National Indian Council on Aging, 1981). As with the general population, with this kind of reported increase among those over 60, problems of vision loss and visual impairment are considerable among elderly Native Americans (American Indians and Alaskan Natives).

Among American Indians the incidence of visual impairment and blindness is higher than the general population due to the high incidence of diabetes and resultant diabetic retinopathy, a leading cause of blindness. (The four leading causes of blindness among persons over 55 in the country include macular degeneration, cataracts, diabetic retinopathy and glaucoma.) Among Native Americans, diabetic retinopathy is the most highly reported eye condition, followed by the incidence of cataracts and glaucoma. The incidence of macular degeneration, however, appears lower among American Indians than in the general population.

Next to the abuse of alcohol and alcoholism, diabetes is the number one health problem among American Indians. In most tribes

diabetes has reached epidemic proportions. One in every three American Indians is at risk of developing Type II (non-insulin dependent) diabetes (Brosseau, Bata, and Marquart, 1984). Firm data on the exact numbers and percentages of visual impairment among American Indians is not known. However, many reports cite statistics in the overall Indian population as well as for specific tribes. For example, seven percent of all Native Americans in the country between the ages of 20 and 74 are diabetic and at risk of developing diabetic retinopathy (National Diabetes Data Group, 1985). Among the Pima Indians, Armstrong (1985) reports that 45 percent of males 45-74 years of age, and 65 percent of females between the ages of 55 and 64 are diabetic and visually impaired as a result of diabetic retinopathy. Dr. Terry Sloan, the Aberdeen Area coordinator for the Indian Health Service, reported during his presentation at the Fifth American Foundation for the Blind's Community Health Representatives Training Session on Aging and Vision Loss (Bismarck, North Dakota, August 8, 1988) that 29-30 percent of American Indians in the Aberdeen Area (service region which encompasses North Dakota, South Dakota, Michigan, Wisconsin and Montana) are diabetic. According to the National Indian Council on Aging (1980), 40 percent of all adults on the reservation have diabetes.

Aston (1984) reported that 13.5 percent of all elderly American Indians 55-64 were visually impaired due to diabetic retinopathy, the highest percentage among five eye diseases (conjunctivitis, cataracts, diabetes, macular degeneration and

glaucoma), and that 8.2 percent of elderly American Indians had diabetic retinopathy between the ages of 65-71, still the highest in this age group. Because of the high prevalence of diabetes among American Indians, they experience vision problems at a greater rate than the general population.

These statistics document the need for greater knowledge and understanding of older visually impaired persons, of special populations of older visually impaired persons, of the problems of vision loss, and the need for professionals across disciplines working with older people to be increasingly prepared to plan for and provide services to this diverse and growing population of visually impaired older persons.

The Blindness Field and Service Delivery System

As the population of those over the age of 60 increases dramatically, and with those over 85 years of age expanding most rapidly, sensory loss (both vision loss and hearing impairment) is having considerable impact on the lives of those who are living longer. The fields of blindness and aging are confronted with growing numbers of older persons in need of a vast array of services from both the aging and blindness service delivery systems. The same holds true for all health care and social service providers across professional disciplines. Yet, many feel unprepared, that they have an insufficient knowledge base in blindness and, most specifically, in the combined area of aging and blindness, which would prepare them to provide high quality

services. Many also feel they lack the skills with which to assist or even interact with blind and visually impaired clients.

Because of the range of physical and psychological factors confronting the more than 2 million documented severely visually impaired older persons, the problem is a multidimensional one. Visual impairment, unlike some of the commonly thought of life-threatening conditions such as heart disease, stroke or the devastating effects of Alzheimer's Disease, is not life-threatening, but it speaks to the quality of life of so many older Americans. It also points to the need for psychological and social adjustment and the need to learn new methods to accomplish lifelong skills. In the scheme of things it may seem minor, an inconvenience, yet it attacks both physical and psychological independence, an intangible quality valued so highly by many older people particularly at this stage of the life cycle when other conditions and losses and crises are occurring.

Blindness and visual impairment among the elderly can result in a devastating impact on their lives. For example, it can lead to both physical, social and psychological isolation, to a decrease in actual or perceived participation in daily living activities, to a loss of independent mobility and physical freedom and a loss of self-confidence, self-worth and self-esteem.

Services for blind and visually impaired persons such as rehabilitation services (teaching blind and visually impaired persons adaptive techniques to accomplish activities of daily

life) and low vision services which can help the visually impaired person make the best use of remaining vision, can make a major difference in the life of an older person who is gradually losing his/her vision or who is severely visually impaired. But these rehabilitation services must be accessible and responsive to the needs of older visually impaired persons in general and to specific populations of elderly visually impaired persons such as elderly Hispanics, Native Americans and others who, for language and cultural differences, experience barriers to access to services.

As is too often the case where no specific mandate is made to serve a special population, a minority group or rural population, for example, little or no targeted outreach is carried out on the part of service providers to address the needs of any special group. This is certainly true for the population of elderly American Indians. While these community-based rehabilitation services are generally "available to everyone", frequently American Indians have no knowledge or experience of such services. Language and cultural differences from the "majority" population contribute to the lack of, or limited access to, rehabilitation services for elderly American Indians and their families in many areas including visual impairment.

Lack of access to rehabilitation services among blind and visually impaired elderly American Indians may lead to premature institutionalization for those who have no family care. Given the steadily growing number of elderly in our population and the

increasing prevalence of visual impairment and blindness in the overall population of those over 55, there is a need for the elderly blind and visually impaired to acquire daily living skills training through rehabilitation services in order to ensure their ability to continue to live outside the institutional setting and within the valued American Indian family.

Historically, rehabilitation services have been difficult for the general population of blind and visually impaired elderly persons to acquire, due largely to a major focus in the field of blind rehabilitation on vocational rehabilitation for remunerative employment. The idea that persons requiring rehabilitation for independent living was given less attention until the exponential expansion of the older population. Only recently has Congress recognized the rehabilitation needs of elderly blind and visually impaired persons by appropriating funds targeted for this population. Title VII-Part C (Independent Living Services for Older Visually Impaired Persons) came into being at the time of the reenactment of the Rehabilitation Act in 1978. In 1987 twenty-five grants of $200,000 each were awarded. The purpose of Title VII-Part C is to provide community-based independent living skills training to older blind and visually impaired elderly in order to enable them to function as independently as possible in their own homes and communities, and to prevent premature and costly institutionalization. In 1988 and 1989 half the states in the country received such grants; however, many of the originally funded states were not refunded. Different states

were funded through an annual competitive process. This limited the non-refunded states' abilities to continue the special services they had begun. However, Title VII-Part C funds have allowed states to begin to address the service needs of many older visually impaired persons. Of particular significance is the fact that in 1990 seven Title VII-Part C funded states have identified outreach and service delivery to American Indians as a service priority. The states at the time of this writing include Arizona, Idaho, North Carolina, Wisconsin, Montana, South Dakota and Texas.

In 1990 leaders in the blindness field are calling for 26 million dollars to be allocated to Title VII-Part C, which would allow every state to be funded at the $250,000 level. This would serve to provide an equitable distribution of funds to help states address their regional priorities on behalf of older persons who are blind and visually impaired.

The Indian Health Service and the Elderly American Indian

A general perception of the Indian Health Service (IHS) is that it has primarily focused its service dollars on the treatment of children and young adults. The IHS health care system is also characterized by an acute care focus, as are many health agencies throughout the country. Recent epidemiological data on the diseases associated with older American Indians indicate that they have quite a different set of diseases than those experienced by their younger American Indian counterparts (Manson and

Callaway, 1988). At first glance, current IHS emphasis on youth and family appears to have less focus on the health care needs of older American Indians. Chronic and degenerative diseases predominate and are the primary causes of death for elderly persons in this population, as is the case in the general population. According to the National Indian Council on Aging (1981), mounting evidence indicates that 77 percent of all Indian persons over age 60 suffer limitations in their ability to perform activities of daily living, due to these conditions.

One such condition is that of blindness or visual impairment. What is needed for the population of older American Indians is a perspective of a continuum of long-term care and support of older Indians to reduce dependency and premature and unnecessary institutionalization. There are exciting efforts by individual tribes and within specific service areas which address the emerging problems of care posed by the needs of older American Indians.

Since the ultimate goal of the project is to prevent premature and unnecessary institutionalization by providing visually impaired American Indian elders and their family members with the independent living skills which can enable them to continue to function independently and interdependently in their home environment, a look at the American Indian nursing home situation is in order.

A technical report of the 1981 White House Conference on Aging indicated that approximately 4,600 older Indians reside in non-Indian nursing homes. American Indian nursing home construction only began in the 1960's and there are currently 10 reservation nursing homes serving 435 residents. Bell, Kasschau and Zellman (1978) argue that the lack of information about American Indian elders has delayed the process of designing and implementing a solid service delivery system on behalf of the group from community-based to residential care.

A wide range of noteworthy community-based long-term care services can be found in American Indian and Alaskan Native communities. Congregate meals and nutrition programs probably are the first and oldest forms of such services, funded under Title XX of the Social Security Act and Title II-Part C or Title VI of the Older Americans Act. These efforts frequently include group meals, menu planning, nutrition education, occasional activities, employment projects and exercise programs. The impetus for many Indian communities' involvement in other aging related services can be traced to early successes of nutritional programs for elderly Indians.

Virtually every Indian community has a noninstitutional local point for aging-related activities, albeit most are far from comprehensive. These local points take several forms in addition to the classic senior center model. A multi-site system typically has developed where the elderly Indian population is widely dispersed across the reservation. On small reservations

which cannot support a separate facility, community centers may sponsor senior activities and set aside space for exclusive use by elderly residents. Some communities have tried mobile approaches, such as senior centers on wheels. Activities include limited social services, information and referral, and friendly visiting by well elderly persons.

In-home services are the most prominent option for elderly Indians. These services are delivered by tribal community health nurses and community health representatives (CHRs). CHRs have been described as the cornerstones of in-home care of elderly Indians. Indeed, CHRs are responsible for all home health care within the homecare services programs. CHRs are more often than not the older Indian's only link to the accute health care system.

The critical part CHRs play in caring for the elderly population was recognized by a National Task Force convened in 1983 to identify areas of program specialization. In the resulting position paper, "Statement and Definition of Indian and Alaska Native Community Health Representative Program Health Care Delivery Areas", gerontological services were identified as one of the six sub-specialty fields.

The changing demographics of the American Indian population and epidemiologic implications thereof call for tribes, the IHS and other concerned agencies to plan more systematically for the provision of long-term care services for older adults. Training CHRs in the issues of Aging and Vision Loss and Independent

Living Skills is in keeping with the multifaceted role and function of the Community Health Representative Program and the ability of this service group to reach the older American Indian experiencing vision problems.

Project Preparation

The conceptualization of this project grew out of the American Foundation for the Blind's history of collaboration with a number of Indian tribes in the West and Southwest on similar programs. AFB's Social Research Department has also been working on the Hopi reservation assessing and addressing the needs of blind and visually impaired members of that tribe.

In 1986, one of the Foundation's national consultants on aging was invited to conduct a one-day training program for the Directors of the Creek Nation's Title VI programs in Okmulgee, Oklahoma to identify vision related services and rehabilitation services and accessibility to such services to elderly Creek Indians. When the participants learned of the possibilities and extent of the learning which could take place on the part of the IHS workers working directly with elderly American Indians, the Title VI employees expressed interest in future trainings.

A review of the literature revealed a dearth of information regarding demographics on elderly blind American Indians and even less regarding rehabilitation services for this population. The IHS had no documented statistics on the prevalence of blindness or severe visual impairment among American Indians throughout the

country. At the time the proposal was written to initiate this project there was not even a computerized count of the number of eyeglasses dispensed by the IHS to American Indians for a given year.

Due to the lack of hard data but knowledge of the fact that older American Indians were experiencing vision loss through professional contacts with Native American leaders, the American Foundation for the Blind recognized the need to attempt to begin to address the service need of visually impaired elderly American Indians. In November 1986, the American Foundation for the Blind's two National Consultants on Aging and AFB's Governmental Relations Specialist met with representatives from national Indian organizations concerned with aging issues to determine more fully the extent of the need for rehabilitation services and low vision services among elderly American Indians and the role of AFB in helping to meet this need. Specifically, the Foundation's staff met with national representatives including Curtis Cook, Executive Director, National Indian Council on Aging; Karen Funk, National Congress of American Indians; Jake Whitecrow, Director, National Indian Health Board; Nicky Solomon, Director of Community Health Representatives, Indian Health Service; Betty White, the then Chairperson, National Association of Title VI Grantees, Yakima Indian Nation; and Steve Wilson, Chairperson of the Oklahoma Indian Council on Aging, Elderly Program for the Creek Nation.

Conclusions reached through consensus among representatives of the above listed organizations/programs in the country were:

1) there are a large number of unserved and underserved elderly blind and visually impaired American Indians in this country;
2) there is a high incidence of diabetes among elderly American Indians, placing them at risk of developing diabetic retinopathy;
3) the American Indian elderly population has no clear access to existing rehabilitation services for the blind and visually impaired in their region due to language and cultural barriers to these services;
4) American Indians will not seek these services because
   a) they are not aware that they exist
   b) they do not know they are eligible for services
   c) they accept vision loss as a normal part of aging, as do many older people across cultures, and
   d) services for the blind and visually impaired are provided by Anglo workers
5) in order for this population to learn about and take advantage of rehabilitation services for the visually impaired, these services must be available from indigenous workers;
6) service providers with regular access to elderly American Indians, who are themselves American Indians

and are trusted by elders, would be best suited to serve this function, i.e. CHRs, because:

a) they are American Indians who work primarily with their own tribes and are, therefore, knowledgeable of the client's thinking, receptivity, tribal beliefs, culture and the language of their respective tribe;

b) they have basic knowledge of health care and could be taught early signs by which to detect vision loss;

c) they provide health care within the homes of American Indians or in Indian settings such as clinics or nutrition sites, both on reservations and in the community;

d) they are the cornerstone of care for the elderly

e) they are a recognized, established, trusted group of paraprofessionals with regular in-service training programs in which content on aging and vision loss and independent living skills could eventually be infused into the curriculum.

7) outside professional trainers are needed to train CHRs in order for them to train older visually impaired and blind American Indians in independent living skills and adaptive techniques in order for them to continue to perform activities of daily living

8) the rehabilitation process must focus not only on the elderly blind and visually impaired American Indians but also on their family members in order for successful rehabilitation to take place

9) the American Foundation for the Blind's professional staff had the skills to provide training on aging and vision loss and independent living skills to the population of CHRs.

Project Goals and Objectives

The goal of the American Indian Rehabilitation Project is to provide older American Indians who are experiencing vision problems the skills useful in carrying out daily activities as independently and as interdependently as possible in their own homes and communities to prevent unnecessary and undesired dependence on others and premature and unwarranted institutionalization.

This project was conducted in two phases. The objectives of Phase I of this project were:

1. to develop a five-day, seven module model curriculum for use in training approximately 200 CHRs during the course of the project and to serve as a model for further training after the course of the project,
2. to train approximately 200 CHRs representing as many tribes as were interested at five separate training sessions, approximately 40 trainees per session, at the

following sites: Tulsa, Oklahoma; Albuquerque, New Mexico; San Francisco, California; a second training in Albuquerque; and Bismarck, North Dakota,

3. to evaluate the outcomes of the training sessions by assessing the extent to which CHRs were utilizing the information and skills learned during the course of the training,
4. to disseminate the findings of the training and the model curriculum to the blindness, aging and Native American service delivery systems.

As Phase I drew to a close it was apparent to AFB and IHS that an additional component was necessary to ensure that future training sessions would be available to other community health representatives. To that end, Phase II was developed.

The objectives of Phase II were:

1. to develop a Trainer Preparation Curriculum (the same seven module model curriculum described above), with additional training resources,
2. to develop a four hour component of the course to be incorporated into the 3-week basic training program for all new CHRs,
3. to train a cadre of 8 American Indian professionals affiliated with the IHS as CHR program trainers in the areas of aging and vision loss issues and independent living skills training (a 2-week training program including a 1-week practicum),

a. 4 new trainers to be certified to teach the course in its entirety, week-long "specialty training"

b. 4 to be certified to teach a four hour component of the course to be incorporated into the CHR basic training program

4. to train an additional 50 CHRs in two sessions taught by the new trainers,

5. to conduct one of the CHR training sessions in Alaska for 20 CHRs to be carried out by the new trainer from Alaska and one other new trainer to meet this identified extreme gap in CHR training, and thus provide two of the new trainers with an additional training experience during the course of the project,

6. to develop a joint agreement with the Indian Health Service Community Health Representative Program to conduct four "specialty trainings" using the AFB seven module curriculum during the course of the fiscal year following the funded project,

7. to evaluate the effectiveness of the training of the 8 Native American trainers by:

   a. designing pre- and post-training assessment instruments to be used in evaluating the new American Indian trainers' knowledge of:

      1. blindness and low vision

      2. the psychosocial aspects of aging and vision loss

3. advocacy skills in accessing community-based aging and blindness resources
4. identifying resources within their regions and throughout the country where they may be providing CHR training

b. designing pre- and post-training evaluation instruments to access each trainer's skills in teaching:
1. orientation to the environment, walking in a familiar environment, sighted guide, and other safety techniques
2. daily living skills
3. effective communication of this information and skills to CHRs so they in turn are able to teach elderly blind and visually impaired American Indians.

8. to disseminate project outcomes by:
a. Disseminating the findings at the local, state and federal level to key agencies and organizations in the fields of aging and blindness, such as area agencies on aging and state commissions for the blind, particularly in states with the highest concentration of elderly American Indians.
b. Disseminating the training model to national Indian organizations for publication in journals

or newsletters of national organizations, as well as tribal and intratribal publications.

c. Publishing an article for the JOURNAL OF VISUAL IMPAIRMENT AND BLINDNESS on the model and project findings.

d. Submitting articles to two gerontology journals.

e. Disseminating the training modules for dissemination to groups interested in replication.

f. Making presentations at national aging, blindness and Indian conferences.

A complete review of project methodology is presented in Chapter 2.

Chapter 2

METHODOLOGY

This project was designed to improve access to independent living skills training traditionally provided by agencies for the blind to elderly blind and visually impaired American Indians living both on and off reservations across the country. The project goal was achieved by a 2-phase process: Phase I, to teach 200 CHRs about aging and vision loss, and adaptive techniques and independent living skills used to instruct elders in activities of daily living and, Phase II, to conduct a "Train the Trainers" session in order to ensure that the training developed by AFB would be perpetuated by IHS through its own American Indian trained professionals. A second priority for Phase II was to provide a training session to CHRs in Alaska who are far removed from training opportunities.

It is important to note that the original project consisted of only the Phase I demonstration project. Because of the large number of CHR coordinators who reported the need for the training to be extended to additional CHRs, the American Foundation for the Blind and the IHS documented the need for an additional training component. The most appropriate solution was to design Phase II to ensure that future training would be possible, first through AFB and second by IHS professionals trained by AFB in aging and vision loss and independent living skills.

This chapter describes the initial methodology outlined at the conceptualization of the project and at the inception of the training, as well as the modifications made in relation to the training curriculum, teaching methodologies, follow-up activities and evaluation components. Such modifications are in accordance with the design of the project, i.e. to develop over the course of the project the most culturally appropriate training curriculum and effective teaching methodologies to train CHRs to assist elders who are visually impaired.

PHASE I

Project Curriculum

Project staff developed an initial five-day seven module model curriculum to be used to train classes of CHRs in both the issues surrounding the process of losing vision late in life and the skills and techniques of daily living, which could make it possible for American Indian elders to continue to carry out activities of daily living. This would enable them to function as independently or as interdependently as possible in the home, community, on the reservation, and in tribal life.

The seven module model curriculum consists of the following modules:

I Introduction to Rehabilitation and the Concept of Family Rehabilitation

II Understanding Blindness and Low Vision

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III Walking in a Familiar Environment, Sighted Guide and Other Safety Techniques

IV The Psychosocial Aspects of Aging and Vision Loss

V Daily Living Skills

VI Adapted Recreation and Leisure Activities (Cultural, Tribal, Traditional and Religious Activities)

VII Knowledge of and Linkages to Resources and Advocacy Skills Training

Through the above curriculum, AFB's project staff trained 250 community outreach workers (community health representatives) during Phases I and II of the project. The following information, learning experiences and training to acquire new skills were provided:

a. a basic understanding of the concept of rehabilitation and the rehabilitation process for visually impaired persons

b. an understanding of the concept of family rehabilitation and why family involvement is so vital to the rehabilitation of the older person

c. a basic knowledge of low vision, severe visual impairment, legal blindness and total blindness and the kinds of eye care available in the country, including low vision assessment, rehabilitation and adapted low vision devices

d. a sensitivity to the psychological and social aspects of aging and concomitant vision loss from the American Indian perspective

e. hands-on learning experiences in the areas of walking in a familiar environment, the sighted guide technique and other safety techniques for negotiating the physical environment; daily living skills and adaptations for participation in recreation and leisure activities as well as traditional, cultural, tribal and religious activities and accomplishing the activities of daily living

f. information about state and private agencies for the blind in each CHR's community or region, in the areas of vision care, vision rehabilitation and independent living skills training, for additional assistance beyond the training of CHRs

g. advocacy skills to be utilized to link elderly blind and visually impaired American Indians with appropriate service providers in the field of blind rehabilitation

h. information regarding the availability of rehabilitation services beyond those provided by the indigenous trainers, such as formal orientation and mobility training, use of low vision aids and advanced independent living skills training (rehabilitation teaching)

i. literature to be used as learning materials for CHRs concerning aging and vision loss issues and adaptive techniques and independent living skills training for elderly blind and visually impaired American Indians

j. training films shown during the five-day training session addressing the issues of aging and vision loss and rehabilitation.

Project Training Sites and Dates

The project was carried out by conducting seven five-day training sessions, five sessions during Phase I and two sessions during Phase II. The average class size was approximately 32 CHRs.

Training sessions were held in the following locations throughout the country:

Tulsa, Oklahoma (December 6-10, 1987)

Albuquerque, New Mexico (February 8-12, 1988)

San Francisco, California (April 18-22, 1988)

Albuquerque, New Mexico (June 6-10, 1988)

Bismarck, North Dakota (August 8-12, 1988)

Tucson, Arizona (July 31-August 11, 1989)

Portland, Oregon (January 22-26, 1990)

Small to mid-size hotels were used for the week-long training sessions, with CHR trainees staying at the training site throughout the training.

Project Staffing

The project was staffed by the project's principal investigator and director, Alberta L. Orr, National Consultant on Aging at the American Foundation for the Blind; by the Director of Training during the first twelve months, Jamie Casabianca Hilton, National Consultant on Aging at the American Foundation for the Blind, and by the Rehabilitation Teaching Consultant and primary instructor for the training, Dr. Ruth Kaarlela, formerly the Chairperson of the Department of Blind Rehabilitation at Western Michigan University. The project was also staffed by a 21 hour/week secretary. During the preparation phase preceding each training session, project staff recruited local professionals to teach and assist in teaching various components of the curriculum. These professionals included optometrists, ophthalmologists, low vision specialists, rehabilitation teachers, and other professionals from state agencies for the blind.

According to the original design, the rehabilitation teaching consultant would carry full responsibility for conducting each of the five training sessions in Phase I. Regional experts including the low vision specialist, ophthalmologist or optometrist would be called in to discuss eye diseases, low vision assessment, rehabilitation and services, and visual impairments and blindness; rehabilitation teachers would assist both by instructing and observing CHRs during the teaching and hands-on learning exercises in Modules IV and V (Walking in a Familiar Environment and Daily Living Skills Training). A

professional from a local agency for the blind (usually the state agency) such as a rehabilitation teacher, also assisted in Module VII in the discussion of local resources for low vision evaluations, low vision aids, distribution of aids and appliances for the blind and visually impaired, and rehabilitation teaching and orientation and mobility training beyond that taught during the training.

The Director of Training would attend the first session to observe the rehabilitation teacher and to gain a fuller understanding of the CHR population targeted for the training. The project director also would attend a session to learn about those being trained and to monitor the project. However, after the first session it was obvious that at least two (2) full-time project staff were needed for each training session. This helped provide essential small group discussions and individual attention to CHRs during hands-on learning experiences and simulation exercises and for greater monitoring.

Key Staff Job Descriptions

Project Director

The Project Director, Alberta L. Orr, had responsibility for:

1) Overseeing the day-to-day operation of the project;
2) Hiring project staff;
3) Designing the training modules with the rehabilitation teacher;

4) Ongoing work with Director of Community Health Representatives in identifying CHR participants;

5) Collaborating with members of the National Advisory Committee to the project and members of national Indian organizations;

6) Convening two meetings of the American Indian National Advisory Committee;

7) Arranging for press releases, regional press and media coverage;

8) Creating training packets of publications and pamphlets on adaptive learning skills for elderly blind and visually impaired persons for use at on-site training;

9) Serving as trainer during 4 of the 7 trainings;

10) Evaluating the effectiveness of the seven module curriculum at regular intervals, in collaboration with the rehabilitation teacher;

11) Developing, distributing and analyzing follow-up surveys;

12) Monitoring all aspects of ongoing project evaluation;

13) Meeting with Administration on Aging Project Officer in Washington at least twice during the funded project;

14) Preparing all quarterly reports to the Administration on Aging;

15) Analyzing data from pre- and post-evaluations in collaboration with the AFB Social Research Department staff;

16) Making site visits to reservations during the final stages of the project;

17) Writing articles for the JOURNAL OF VISUAL IMPAIRMENT AND BLINDNESS and gerontology journals;

18) Preparing a final project document for the Administration on Aging;

19) Disseminating project findings to the fields of aging, blindness, national Indian organizations, and the IHS.

Job Description for Director of Training: Phase I

The Director of Training, Jamie Casabianca Hilton, had responsibility for:

1) Setting up five on-site training programs in already-identified cities;

2) Making all technical arrangements for the training program;

3) Designing the training module on psychosocial aspects of aging and vision loss;

4) Supervision of rehabilitation teacher and other consultants to the project;

5) Prior to on-site training, contacting state and local agencies for the blind in each state represented by CHRs;

6) Prior to each training session, contacting local and state aging agencies including the Area Agency on Aging and State Units on Aging;

7) Observing various stages of three on-site trainings of CHRs.

Job Description of the Rehabilitation Teacher

The rehabilitation teacher, Dr. Ruth Kaarlela, had responsibility for:

1) preparing the model curriculum for use during training with the project director;
2) developing training materials with the project director;
3) making modifications in curriculum content, teaching methods and curriculum organization with the Project Director;
4) serving as the primary instructor for all of the seven training programs;
5) overseeing the local rehabilitation teachers during the training sessions;
6) reviewing CHR information forms;
7) reviewing the written curriculum reviews and training program evaluations;
8) developing the additional resources to support the curriculum during Phase II;
9) preparing the final model curriculum for dissemination at the completion of the project.

Regional Resource Persons for the Training Sessions

The following persons were invited speakers and resource persons from the regions in which the training session was conducted:

Judy Pool, Geriatric Specialist
Division of Visual Services
Oklahoma City, Oklahoma

Dr. Amanda Hall, Rehabilitation Specialist
University of California
Berkeley, California

Sharon Hudson, Rehabilitation Teacher
Zelma Acevido, Rehabilitation Teacher
Paul Raskin, Rehabilitation Teacher
Peninsula Center for the Blind
Palo Alto, California

Susan Johnson, O.D., Senior Optometrist
Lovelace Medical Center Low Vision Clinic
Albuquerque, New Mexico

Michael Beck, Rehabilitation Teacher
Stanley Mosser, Rehabilitation Teacher
Richard Corcoran, Rehabilitation Teacher
Office of Vocational Rehabilitation
Program for the Older Visually Impaired
Bismarck, North Dakota

Janet Dylla, C.O.T., Vision Specialist
Carondelet St. Joseph's Low Vision Services
Tucson, Arizona

Ray Mungaray, Office Coordinator
Arizona Department of Economic Security
Services for the Blind and Visually Impaired
Tucson, Arizona

Mary Boomer, Rehabilitation Teacher
Claude Garvin, Rehabilitation Teacher
Commission for the Blind
Portland, Oregon

Shari Katz, M.A., Coordinator
Low Vision Services
Devers Eye Institute
Portland, Oregon

Philip McKinney, O.D.
Devers Eye Institute
Portland, Oregon

These professionals made formal presentations during training sessions and served as resource persons for future contacts. Opportunities for use of local specialists varied tremendously from region to region. Where specialists from local agencies participated in a training session, learning and information about local resources and actual access to those resources was tremendously enhanced. A complete list of regional resource persons is found in Appendix V.

National Advisory Committee to the American Indian Rehabilitation Project

This project was also guided by members of a National Advisory Committee. American Indians holding key positions in policy-making and service delivery to elderly American Indians were invited to form a national advisory committee to the project at the time the project proposal was conceptualized. Committee members included Nicky Solomon, Director, Community Health Representative Program, Indian Health Service; Susan Shown Harjo, Executive Director, National Congress of American Indians; Curtis Cook, Executive Director, National Indian Council on Aging, and Steve Wilson, Chairperson, Oklahoma Indian Council on Aging. A CHR who completed the AFB training was added to the committee for participation in the second meeting.

The advisory committee met twice during the course of the project, once in October 1988 and again in October 1989 at AFB's Governmental Relations Office in Washington, D.C. AoA project officer, Marla Bush, also attended the meetings. AFB project staff in attendance included Alberta L. Orr, Project Director; Jamie Casabianca Hilton, Director of Training; Glenn Plunkett, Legislative Specialist, and Dr. Saul Freedman, then the Director of National Services in Aging Department at AFB.

The committee's role was to: 1) assist in determining appropriate training sites at the most appropriate time of year for the tribes in each region to participate, 2) assist in the development of the model curriculum in the area of cultural appropriateness and 3) support the need for the IHS to continue the work initiated by AFB. They provided feedback during the course of the project about the effectiveness of the training of CHRs and its impact on older blind and visually impaired American Indians.

At its second meeting, the advisory committee reviewed the effectiveness of the project and possible next steps to be taken to influence the IHS of the importance of including content on aging and vision loss and independent living skills training into the basic three-week training curriculum of the Community Health Representative Program. Committee members were also interested in influencing IHS to assume responsibility for conducting "specialty trainings" on Aging and Vision Loss after the project's completion.

Community Health Representatives (CHRs) as Trainees

As mentioned earlier, this group of health care service workers were identified as the most appropriate group of paraprofessionals to train because of their routine involvement with elderly American Indians in their own living environment.

There are approximately 1,400 CHRs throughout the country. At the request of Nicky Solomon, Director of the Community Health Representative Program, Indian Health Service, a "call for participants" resulted in 350 CHRs, which represented each of the Indian Health Service Regions in the country, applying to participate in AFB's training program. Two hundred traineeships were available, 40 trainees per class for 5 classes during Phase I of the project. Prior to each training session, project staff and Nicky Solomon met or conferenced by phone to select trainees for each class from the geographic region where the class would be held. Criteria for selection were: 1) length of service as a CHR (the longer the involvement in the job, the more likely they were to continue their service), and 2) the degree of involvement with elders. Where several names were submitted from a service area, priority was given to selecting at least one trainee from each program to assure representation for each program.

When the project was designed, the plan was to train CHRs from the southwest and western states. However, once funding was received and planning meetings took place, IHS presented the need for training of CHRs across the country. In order to attempt to train an equitable distribution of CHRs around the country, the

scope of the training sites was broadened. This presented no problem in training other than the need to ensure that sufficient funds were available to transport CHRs to the nearest training site. The first session was held in Tulsa, Oklahoma where CHRs from up and down the east coast, as well as southeastern states participated, along with CHRs from Oklahoma.

The CHRs for the Tulsa, Oklahoma class came from the following states: Maine, Connecticut, New York, North Carolina, Tennessee, Florida, Oklahoma, Louisiana, Mississippi, Alabama, Iowa and Nebraska.

Trainees for the Albuquerque, New Mexico class came from: Arizona, New Mexico, Nevada, Colorado, and one CHR from Alaska.

Trainees for the San Francisco, California class came from: California, Arizona, Oregon, Washington, Idaho, and one CHR from Alaska.

Trainees for the second Albuquerque class came from: Arizona, New Mexico and Southern California.

Trainees for the Bismarck, North Dakota class came from: North Dakota, South Dakota, Wisconsin, Minnesota, Montana and Michigan.

Trainees for the Tucson, Arizona class came from: Arizona, New Mexico, Nevada, Oregon and Washington.

Trainees for the Portland, Oregon class came from: Oregon, Washington, Idaho and Alaska.

As paraprofessional health care service providers, CHRs are an extremely diverse group. Those trained during this project

ranged in age from 20 to 62; educationally, they ranged from eighth grade to college graduates; the project's classes included CHRs of various job titles and positions including nurses, pharmacy technicians, optometric technicians, health educators, transporters, as well as the health care service workers who provided in-home care. A review of a typical training session follows.

A "Typical" Training Session

Each training session began with background information about the project, how the project was conceptualized, why the training was important and how participants had been selected. The opening of each session was enhanced by an introductory statement made by an IHS staff person, such as an area coordinator of the CHR program in each region, an IHS physician or another designated American Indian involved in the IHS CHR program. This helped to lend credibility to the training being conducted by Anglo trainers and was particularly useful at the inception of the project for it established a reputation and track record for other CHRs to be eager about participation.

Training Materials

During the training, CHRs were given reading materials as part of the training. Booklets and articles distributed included:

- Low Vision Questions and Answers

- Cataracts and Their Treatment
- What Can We Do About Limited Vision?
- A Vision Impairment of the Later Years: Macular Degeneration
- Diabetic Retinopathy
- Diabetes, Vision Impairment and Blindness
- Understanding and Living with Glaucoma
- Age Page - "Aging and Your Eyes"
- Aging and Vision: Making the Most of Impaired Vision
- How Does a Blind Person Get Around?
- What Do You Do When You See a Blind Person?
- Techniques for Assisting Older Blind Persons
- Kitchen Hints
- Making Life More Livable
- Safety for Older Consumers

CHRs were also given the following resource materials:

- AFB Products for People with Vision Problems
- AFB Regional Offices
- Helen Keller Deaf-Blind Regional Offices
- National Eye Care Project
- State Agencies Serving the Visually Handicapped in the U.S.
- Application Form for Free Library Service - Talking Books
- List of blindness agencies and resources by state

CHRs were given the following non-optical equipment for use in their work with visually impaired clients:

Hand Sewing Kit

Hi Marks

Signature Guide

Double Spatula

Low Vision Cards

Rotary Dial

Braille Alphabet and Numbers Card

During the hands-on training sessions CHRs had the opportunity to see and learn to use the following pieces of adapted equipment:

1. Low vision watches
2. Braille watches
3. Adapted alarm clock
4. Large print telephone dial
5. Large print pushbutton telephone adaptation
6. Oven mitt
7. Double spatula
8. Large print kitchen timer
9. Braille kitchen timer
10. Liquid leveler
11. Self-threading needle
12. Adapted tape measure
13. Braille and low vision playing cards
14. Adapted checkers

15. Adapted dominos
16. Large print and braille bingo boards
17. Signature guide
18. Check writing guide
19. Envelope addressing guide
20. Marks Script writing guide
21. Braille slate and stylus
22. Talking book machine
23. Folding cane

The eye care specialists who conducted Module II (Understanding Blindness and Visual Impairment) brought optical devices for maximizing remaining vision. These included:

Hand-held magnifiers
Stand magnifiers
Telescopes
High intensity lamps
Closed circuit TVs
Special glasses

An outline of the Training Curriculum Objectives and Expected Outcomes, as well as the Day-by-Day Training Curriculum presented below, provides an overview of the content both in information, skill areas, module objectives, teaching methods and expected outcomes as well as a timetable for each training curriculum module.

Training Curriculum Objectives and Expected Outcomes by Training Module

Module I Introduction to Rehabilitation and the Concept of Family Rehabilitation

Objectives

1. To define the meaning of rehabilitation and to identify its elements.
2. To explore how rehabilitation can enhance the lives of elderly Indians and their families.
3. To identify the potential for increased independence through rehabilitation as well as increased interdependence, the central focus of tribal life.
4. To describe the rehabilitation process and the settings in which it is provided.
5. To describe the unique characteristics of the older person as a rehabilitation client.

Expected Outcomes

1. The trainees will define the concept of rehabilitation.
2. The trainees will be able to describe the rehabilitation process related to visual impairment.
3. The trainees will be familiar with the common blind rehabilitation settings.
4. The trainees will be able to describe six characteristics which may be unique to the elderly client as a rehabilitation candidate.

5. The trainees will understand rehabilitation within a cultural context.

Module II Understanding Blindness and Low Vision

Objectives

1. To identify and describe the most common eye diseases among elderly people.
2. To become familiar with the concepts of legal blindness, low vision and severe visual impairment.
3. To recognize when a vision problem may be present.
4. To become familiar with low vision resources.
5. To become familiar with non-optical assistive devices for persons with low vision.

Expected Outcomes

1. Trainees will be able to name four leading causes of vision impairment.
2. Trainees will be able to describe the functional implications of each condition.
3. Trainees will be able to define: legal blindness, low vision, optical aid, non-optical aid.
4. Trainees will be able to name eight ways in which to enhance low vision.
5. Trainees will identify three resources available to them which will be of assistance to a visually impaired client.

Module III Walking in a Familiar Environment (Sighted Guide)

Objectives

1. To become aware of cues in the physical environment.
2. To develop guiding skills.
3. To develop trailing skills.
4. To incorporate the standard O&M terms into trainees' understandings and vocabulary.
5. To become sensitized to ways in which visually impaired persons take in information.
6. To become aware of safety techniques related to visual impairment.

Expected Outcomes

1. Trainees will work in pairs to teach each other skills, alternating the roles of instructor and "client" under blindfold and by using simulators, which simulate various degrees of vision loss.
2. Trainees will guide a colleague correctly and efficiently and seat the person.
3. Trainees will be able to define key terms in O&M.
4. Trainees will teach one skill.

Module IV Psychosocial Aspects of Aging and Vision Loss

Objectives

1. To explore the meaning of vision loss to the individual American Indian elder and significant others.

2. To develop sensitivity toward the feelings of the visually impaired person.
3. To gain insight into the changes in relationships which may occur when a family member experiences vision loss.
4. To describe the losses associated with vision loss as it relates to aging.
5. To understand the reactions to vision loss; generally accepted reactions; reactions observed/experienced by trainees.
6. To explore reactions from a cultural perspective.

Expected Outcomes

1. Trainees will be sensitized to feelings about vision loss.
2. Trainees will explore their own attitudes toward vision loss.
3. Trainees will have an understanding of what it is like to lose vision as an older person.

Module V Daily Living Skills

Objectives

1. To have trainees learn adapted techniques under simulation (the use of occluders or simulators).
2. To have trainees teach these techniques to another trainee.
3. To become aware that there are adaptive techniques to perform basic activities of daily living.

Expected Outcomes

1. Kitchen Skills:

   Peeling, slicing, dicing

   Using appropriate techniques and under blindfold or simulation trainees will:

   - pare a potato
   - dice a potato
   - scrape a carrot
   - slice a carrot
   - teach a colleague one skill

   Pouring, spreading

   Using appropriate techniques and under blindfold or simulation trainees will:

   - make a peanut butter/jelly sandwich
   - fill a glass or cup with cold water
   - food preparation specific to the tribe
   - teach a colleague one skill

2. Sewing

   Using appropriate techniques and under blindfold or simulation trainees will:

   - thread a needle with a threader
   - measure a piece of cloth
   - stitch a hem
   - sew a button
   - teach a colleague one skill

3. Communication techniques for persons with low vision

   Using appropriate techniques and under blindfold or simulation trainees will:

   - . write a line
   - . sign their names
   - . tell time
   - . prepare three labels
   - . teach a colleague one skill

4. Trainees will simulate the experience of vision loss to get a sense of their clients' experiences.
5. Trainees will develop a set of verbal cues to use in instructing clients.

Module VI Adapted Recreation and Leisure Activities

(Cultural, Traditional, Tribal, Religious)

Objectives

1. To assess the usefulness of adapted games to American Indians (braille and large print bingo, checkers, chess, dominoes, playing cards).
2. To develop a "philosophy" of meaningful use of time as it relates to American Indian elders.
3. To develop strategies for helping clients continue prior interests in activities.
4. To identify existing and potential recreational/leisure pursuits and resources from a cultural perspective.

Expected Outcomes

1. Trainees will become familiar with ways of adapting leisure/recreational, cultural and traditional activities for elderly visually impaired clients and apply them to their individual tribal activities.
2. Trainees will apply knowledge regarding visual impairment to performing current client activities.
3. Trainees will develop plans for expanding clients' opportunities.
4. Table games

   Using appropriate techniques and under blindfold or simulation trainees will:

   - identify braille cards
   - understand adaptations of four games
   - explore adaptations to a cultural recreational activity
   - teach a colleague one skill by exercising the use of instructional and directional verbal cues

Module VII Knowledge of and Linkages to Resources and Advocacy Skill Training

Objectives

1. To become aware of the local and regional resources for blind persons in CHR's service area.
2. To learn what specific services are available.

3. To learn how to gain access to these services.
4. To learn advocacy skills to seek services to benefit older American Indian clients.

Expected Outcomes

1. Trainees will develop resource files of national, state and local (public and private) resources for blind persons.
2. Trainees will understand the types of services available from each of the resources.
3. Trainees will understand the procedures to follow in seeking rehabilitation services.
4. Trainees will be able to list the elements of advocacy.

Teaching Methods

The teaching methods used included:

- lectures
- large group discussions
- simulation exercises
- hands-on learning experiences
- training films
- role playing
- small group discussions

This multi-method teaching strategy, important in all training, was essential in the teaching of American Indian CHRs. As workers CHRs are accustomed to "doing" rather than "sitting".

Interspersing lectures with hands-on learning experiences and simulation exercises helped to ensure a full day of training.

Day-by-Day Training Curriculum Outline

Below is a timetable of the week-long training, indicating the length of time spent on each curriculum module.

Module I - Monday p.m.

Introductions

1.1 Overview of the AFB American Indian training project by project staff person

1.2 Overview of the need for the training presented by an IHS staff person

1.3 Staff introductions

1.4 CHR introductions

Introduction to Rehabilitation and the Concept of Family Rehabilitation

Film: What Do You Do When You See a Blind Person?

CHR Information Forms are completed

Pre-Training Attitude Tests are completed

Assignments described and/or distributed

Module II - Tuesday a.m.

Understanding Blindness and Low Vision

Module presented by an eye care specialist

2.1 "Normal" changes in vision with age

2.2 Definitions of:

Visual impairment/partially sighted

Low vision

Legal blindness

Severe visual impairment

Total blindness

2.3 Leading causes of visual impairment and blindness among elderly persons

Cataracts

Glaucoma

Diabetic retinopathy

Macular degeneration

2.4 Functional implications of diseases of the eye

2.5 Film: Not Without Sight

2.6 Low vision services

2.7 Optical aids

2.8 Environmental modifications to enhance remaining vision

Module III - Tuesday p.m.

Walking in a Familiar Environment (Sighted Guide and Other Safety Techniques)

3.1 Brief background

3.2 Definitions

Orientation

Mobility

3.3 Travel aids

Human guide

Dog guide

Cane

Electronic equipment

3.4 Walking with a human guide

Position

Negotiating narrow spaces

Negotiating stairs

Seating

Entering/leaving a car

3.5 Walking without a guide

Trailing

Protective techniques

Sound localization

3.6 Room familiarization

3.7 Assignment: Personal Contact, pp. 6-12

Module IV - Tuesday p.m.

Psychosocial Aspects of Aging and Vision Loss

Small group discussion by CHRs concerning:

4.1 Losses

4.2 Reactions

4.3 Attitudes from the American Indian's perspective

4.4 Family reaction to vision loss and rehabilitation

Large group discussions with each group reporting the results of this group discussion.

4.5 Film: Aging and Vision: Declarations of Independence

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4.6 This section may also include the use of role playing where trainees are comfortable with this learning strategy.

Module V - Wednesday a.m. and p.m. and Thursday a.m.

Daily Living Skills

Skills are taught at learning stations. Participants work in pairs.

Wednesday - a.m.

5.1 The elderly visually impaired person as a learner

5.2 General principles of instruction as well as those related to the teaching of older persons

5.3 Communication skills

Telephone dialing

Rotary

Push-button

Telling time

Clocks and watches

Adapted alarm clock

Braille watch

Signature guide

Check writing guide

Envelope addressing guide

Large print

Braille

Use of cassette recorder

5.4 Personal grooming

Brushing teeth

Shaving

Applying lipstick

5.5 Eating skills

Place setting/food location

Cutting food with knife and fork

Using salt and pepper

Spreading

Wednesday - p.m.

5.6 Clothing care

Clothing identification

Clothing organization

Adaptive sewing items and techniques

5.7 Money identification

Coins

Paper Currency

5.8 Film: Blindness: A Family Matter

Thursday - a.m.

5.9 Household management

Cleaning a surface

Identifying personal and household items

Organization

5.10 Kitchen Safety

Pouring liquids

Use of knives

Centering pots and pans on stove

Cooking on a woodburning stove

5.11 Distribution of Adapted Equipment

Large print rotary telephone dial

Braille alphabet and numbers card

Sewing kit

Hi Marks

Signature card

Double spatula

Low vision playing cards

Module VI - Thursday p.m.

Adapted Recreation and Leisure Activities

6.1 Recreation activities

Individual

Group

6.2 Adapted braille and low vision games

6.3 Group discussion of cultural activities as they relate to individual tribes

Module VII - Thursday p.m.

Knowledge of and Linkages to Resources and Advocacy Skills Training

7.1 Federal resources

State resources

Local resources

7.2 How to gain access to resources

Discussion of advocacy skills training on behalf of the elderly visually impaired American Indian to gain access to resources

Completion of the Written Curriculum Review

Friday - a.m.

1. Completion of the Post-Training Attitude Test
2. Wrap-up of 7 Module Curriculum
3. Questions and Answers
4. Review of the completed Written Curriculum Reviews
5. Completion of the Training Program Evaluation Form
6. Distribution of Certificates

Information Gathering and Assessment Instruments

Project staff created information gathering and assessment instruments in order to learn about CHRs' caseloads, their experience with blind or visually impaired persons, their opinions and attitudes about blindness and blind people, and what they hoped to gain from the training session. The CHR Information Form was a pre-training instrument completed by each CHR during the first session of the week-long training (see Appendix C). This form gave project trainers background information regarding the following:

- the number of clients in each CHR's caseload
- the number of elderly clients in the caseload (those over 55)

- the number of elderly clients who have "poor eyesight" or are "blind"
- in what settings CHRs saw clients
    - in the home
    - on the reservation
    - in the community
    - at a nutrition site
    - in a clinic
    - transporting clients to and from their homes and medical settings (hospitals, clinics, or nutrition sites or other settings)
    - other locations
- whether or not the CHR had any training in visual impairment
    - the nature of the training in visual impairment
    - the primary problem(s) elderly Native Americans experience when losing their vision or becoming blind
- what resources exist in each CHR's area for clients who are visually impaired or blind
- what experiences each CHR has had with persons who have trouble seeing or are blind
- what each CHR hopes to learn during the training program.

After the second training session, project staff developed a Pre- and Post-Training Attitude Test to assess CHRs' knowledge of blindness and blind persons as well as their attitudes about blind persons. The pre-test was administered during the first session. The same test was administered as a post-test during the last day of the training to assess knowledge gained and attitude changes (see Appendices D and K).

The following evaluation instruments were used during the project:

1) The Training Program Evaluation was used to determine the extent of usefulness of curriculum content to CHRs, particularly as it related to cultural application, the elderly American Indians they were serving, and to evaluate the effectiveness of teaching methodology,
2) The Written Curriculum Review was used at the end of each training session to determine the extent of trainees' learning after the week-long session,
3) The Follow-Up Survey was designed to determine the extent to which CHRs were able to make use of information, skills acquired and materials distributed once they returned to work with elderly American Indian clients, and in their work with other CHRs.

The Training Program Evaluation form assessed the extent to which each area of learning within each module was helpful and culturally relevant to each CHR for his/her future work with visually impaired and blind clients, and the extent to which each

teaching method was useful in the learning process both in acquiring knowledge and in skill acquisition. Each CHR was also asked how the week-long training program effected him/her personally and professionally (see Appendix H).

Two methods were used to evaluate knowledge learned and skills acquired during the training sessions. These were: observation of skill acquisition during hands-on and observation during simulation exercises, and a Written Curriculum Review.

The Written Curriculum Review asked questions related to each curriculum module. Questions by module are listed below.

Module I Introduction to Rehabilitation and the Concept of Family Rehabilitation

1. What is rehabilitation?
2. List two reasons why it is important to involve family members in the rehabilitation of the older visually impaired person.

Module II Understanding Blindness and Low Vision

1. What is legal blindness?
2. List two of the leading causes of blindness among the elderly American Indian.
3. List two types of low vision aids which can assist visually impaired clients.

Module III Walking in a Familiar Environment, Sighted Guide and Other Safety Techniques

1. List three ways in which color contrast can be used to help a low vision client in orientation to an indoor environment (particularly the home).
2. Name two aids a blind person can use to get around independently.
3. Describe the technique called "Sighted Guide".
4. List three ways a totally blind person takes in information from the environment.
5. List three points to bear in mind when you are teaching an older person new skills or techniques.

Module IV The Psychosocial Aspects of Aging and Vision Loss

1. List three possible reactions to vision loss among elderly American Indians.

Module V Daily Living Skills

1. In the area of Communication Skills, describe one method you could use to teach a client to use the telephone independently.
2. How would you instruct a blind person to identify and organize money (coins and bills)?
3. Describe one technique for putting toothpaste on a toothbrush.

4. In the area of Personal Management, list three ways of identifying clothing.
5. In the area of Eating Skills, describe how you would help a blind person know what is on his/her plate.
6. In the area of Household Management, describe how you would teach a client to clean a flat surface.
7. In the area of Pouring, how would you teach a client to pour cold liquids?

Module VI Adapted Recreation and Leisure Activities

1. Name four table games which have been adapted for participation for the blind and visually impaired.

Module VII Knowledge of and Linkages to Resources and Advocacy Skills Training

1. List three types of agencies which may be helpful in serving a blind client in your area (near your reservation or in your community).
2. List two points which are important to bear in mind when advocating on behalf of blind and visually impaired clients (and clients in general).

See Appendix G for the actual format of the Written Curriculum Review.

Client Assessment Form

A Client Assessment Form was developed for CHRs' use in their work with clients and was designed to give CHRs some guidance in what to look for when working with American Indian elders who may possibly be experiencing vision loss. The form related to activities of daily living and the CHR's assessment of whether an older person could do a task independently, with assistance, was interested in learning an adaptive technique, or was not ready for learning at the time. While this form did not become an official IHS form, it provided CHRs with a guideline for evaluating the functioning of their elderly clients (see Appendix E).

Follow-Up Component to the Training Sessions

As originally designed, the follow-up component consisted of conducting on-site (in-home) post-training session observation of a random sample of CHRs to observe their use of the knowledge and skills learned during the training session and the extent to which the CHR was able to transfer that learning to teaching a blind or visually impaired client and family member(s) a new skill or adapted technique to perform an old or routine task or activity.

Once funded, the Director of the Community Health Representative Program strongly expressed discomfort with the design of the follow-up component.

The follow-up component to take place immediately after the week-long training of the CHRs did not allow for time between trainings for CHRs to: 1) synthesize learning, 2) review case-loads for possible visually impaired clients, 3) share the information and skills acquired with supervisors and CHR area coordinators, 4) integrate the learning into day-to-day work with clients, 5) introduce new ideas and concepts to clients prior to instruction, and 6) have an opportunity to begin to operationalize some of the learning. Three clients were visited after the first training session, the results of which will be discussed in Chapter 3.

Because the design of this follow-up component was not a feasible procedure to operationalize within the local American Indian community or on American Indian reservations, an alternative, though a more removed follow-up strategy, was designed. The follow-up strategy carried out during the project was a follow-up survey, designed to identify the extent to which CHRs were making use of their training and the extent to which low vision and blind clients were becoming more independent and being referred to resources for the blind when desired.

Two follow-up surveys were conducted, one during each phase of the project.

During Phase I, the follow-up survey was sent to each CHR trainee three months after the completion of the training session. This allowed time to integrate the learning into day-to-day work with clients, to begin to introduce areas of learning

to elderly visually impaired and blind clients and to begin to instruct these clients in adapted techniques of performing activities which had been discontinued or were at risk of being discontinued because of visual impairment. The survey provided the following information:

- whether or not low vision clients had been identified in each CHR's caseload
- the number of visually impaired clients in each caseload
- the total number of clients in each caseload
- whether or not the CHR had introduced the topic of new adapted techniques to the visually impaired clients
- the number of clients with whom the CHR discussed the adapted techniques
- which techniques were discussed
- the number of clients instructed in adapted techniques
- whether or not clients had been referred to a blindness agency
- to what agency had low vision clients been referred
- which skills learned during training were the most useful in their work with clients
- whether or not the CHR was using sighted guide in work with clients
- whether the CHR had taught sighted guide to low vision clients

- o whether or not sighted guide had been taught to family members
- o whether the CHR has found low vision services in the community or near the reservation
- o if so, where
- o whether any clients had been referred to low vision services
- o whether the CHR had helped visually impaired clients develop adaptive techniques to participate in a recreation or leisure activity
- o whether the information regarding the psychosocial aspects of aging and vision loss discussed during the training had been helpful in their work with clients
- o whether or not the CHR had used any of the adaptive items distributed to each CHR during the training
- o what assistance each CHR felt would be most useful from a local agency for the blind.

The Phase I survey was sent out twice. The first time, the survey was accompanied by a cover letter from the project director explaining the purpose of the survey. The survey was sent with a prepaid and addressed envelope for ease of return. Because of a limited response rate of 26 percent, a second survey was sent to those who had not responded, with a cover letter under the signature of Nicky Solomon, Director of the Community Health Representative Program, IHS, in order to encourage further

response through the IHS affiliate. IHS was also eager to learn CHRs' perspectives on the training once they had returned to their caseloads. The total response rate was 41 percent.

During Phase II, a second survey was sent to all 250 CHRs who had been trained during the course of the project. This survey was also sent twice to gather a sufficient response rate, each time under the project director's name. The second version of the survey used in Phase II included only minor revisions. The response rate was 40 percent. The final survey is found in Appendix N.

The final follow-up component to the entire training project consisted of site visits to three reservations to conduct follow-up interviews with CHRs trained during various parts of the training program. This will be discussed further in the section in this chapter on Phase II of the project. The results of this follow-up component are described in Chapter 3.

The original follow-up on-site strategy was superior in theory to the follow-up surveys actually conducted. However, it did not allow for cultural ideologies among American Indians which made it inappropriate for Anglo trainers to go into the homes of elders for observation when CHRs had had no opportunity to do their new teaching with clients. Even as time went by during the course of the project, in-home interviews presented cultural questions and were not conducted.

PHASE II

The "Train the Trainers" Component

Phase II was an outgrowth of Phase I which generated the need for:

1) additional training sessions for CHRs yet untrained and

2) the special need for training Alaskan Native CHRs.

In order to meet these needs the American Foundation for the Blind designed the "Train the Trainers" Project. AFB recognized that it could not meet all the training needs of future CHRs due to funding and time constraints. Training American Indian professionals who have routine responsibility for teaching and training within the IHS system would serve as a means to transfer the curriculum to IHS for future training needs. The plan was to train eight (8) new trainers in Phase II. (Seven (7) new trainers were actually trained.)

The "Train the Trainers" component used the original curriculum as a foundation. Extensive reading materials related to each module, both required and supplemental, assisted the "new trainers" in developing a knowledge base in aging and vision loss and independent living skills training.

The "Train the Trainers" program was a two-week session. During the first week the new trainers learned using the basic curriculum, while the second week served as their practicum. The new trainers taught a class of 30 CHRs under the supervision of project staff.

Phase II learning and teaching experiences were enhanced by conducting the training at an agency for the blind. Through the cooperation of the Tucson Association for the blind, trainers made use of the facility and its training materials related to the modules in the curriculum. The new trainers also visited a low vision clinic and eye bank at Carondelet St. Joseph's Low Vision Services in Tucson where the module on Understanding Blindness and Low Vision was taught by St. Joseph's professional staff.

Alaska Training Moved to Oregon

An insufficient number of Alaskan CHRs were interested or able to attend the training scheduled for Anchorage. Therefore, the second training of Phase II was moved to Portland, Oregon where a large number of CHRs were asking for training. Alaskan CHRs who were interested came to Portland to participate. A discussion of the Alaskan training issue (a shortage of interested CHRs from Alaska) and its implications is presented in Chapter 3. This Oregon class was taught by two (2) new trainers and two (2) AFB project staff and served as the practicum for two (2) of the new trainers.

Reservation Site Visits

Visits to three Indian reservations were made by the project director to interview CHRs trained during several of the training sessions. Reservations visited included Warm Springs

Confederated Tribes in Warm Springs, Oregon; Yakima Nation in Yakima, Washington, and the Umatilla Confederated Tribes in Pendleton, Oregon.

On-site follow-up interviews were guided by the questions listed below.

1. Describe the composition of your caseload,
   children
   elderly, etc.

2. In what settings do you see clients?

3. How many clients are in your caseload?
   individuals and/or families

4. Were you aware of blind or visually impaired clients in your caseload before you came to the training session?
   During the training session?
   By the completion of the training session?

5. After the training, were you able to identify visually impaired clients in your caseload whom you had not previously identified?
   Immediately after you returned to work?
   Over time?

6. How many visually impaired clients have you identified since the training?
   How would you describe their functioning? (Physical, psychological)
   Do they have any other disability or health condition?

7. Have you been able to help a blind or visually impaired client by sharing information or skills learned in the training?

8. Have you been able to also share with family members?

9. What would you say has been more important--the information you learned or the skills you learned?

10. Have you been able to improve the safety of a blind or visually impaired client?

11. Which skills have been most helpful to your client(s)?

12. In general, which skills do you feel are most helpful for you to know, for your clients, for the type of population

you serve?

Communication Skills
- Telephone dialing
- Telling time
- Low vision materials
- Using a signature guide

Personal Management
- Money identification

Personal Grooming
- Shaving
- Applying toothpaste to toothbrush
- Applying lipstick

Clothing Care
- Clothing identification
- Clothing organization

Using Adaptive Sewing Items

Eating Skills
- Place setting
- Cutting food
- Using salt and pepper
- Spreading

Household Management
- Cleaning
- Identifying household and personal items
- Labeling

Kitchen Safety
- Pouring liquids
- Cutting and paring

Environmental Modifications
- Color contrast
- Lighting

13. Do you remember the sighted guide technique?
Can you demonstrate it to me?
Have you taught it to anyone?
Is it something you think a visually impaired client would find useful? feel comfortable using? teach to others?

14. How would you describe family members' reactions to your instruction with a blind or visually impaired client? Has teaching them skills helped their response?

15. Do you know the closest agency for the blind in your region?
Have you had any contact with the agency?
Prior to the training?
Since the training?
If so, how would you evaluate the assistance you and/or your client received?

16. Have you used or distributed any of the adapted equipment we distributed at the training session, such as Hi-Marks?

17. Do you remember the component of the training about the psychosocial adjustment to vision loss?
Was that information useful to you?

18. We are interested in knowing whether or not visual impairment interferes with the American Indian's participation in traditional activities, cultural events, religious celebrations.
Can you tell me what you think from your experience?
Can you describe a situation?
Was the curriculum model on adapted leisure activity useful to you?

19. Do you ever refer to any of the reading materials provided during the training?
Where are your reading materials kept?
Do others have access to them?

20. What happened when you returned to your work after the week-long training session?
Did your supervisor inquire about the training?
Did any of your co-workers?
Did you share information with others where you work?
How did you share that information--make a written report, make a presentation at a staff meeting, provide in-service training, participate in a health fair?

21. Would you say that the training is something you use regularly or is information stored for future reference?

22. What can you say about the training that I can share with others around the country?

These questions generate important follow-up information because they help us to know what to emphasize in further teachings, what information to eliminate in the curriculum and what information can be considered optional.

Findings from the follow-up visits are outlined in Chapter 3.

Dissemination Activities

The following dissemination activities were designed:

1. the findings of the project will be disseminated to Indian organizations throughout the country through the final report and curriculum
2. state and private agencies for the blind and visually impaired will receive a ten page abstract of the project, as well as a copy of the curriculum
3. state offices and Area Agencies on Aging will receive the Project Briefs.

Presentations about the project were made at the annual meetings of national aging organizations, at prominent conferences in the field of blindness, and at key Indian organizations interested in the project (see Appendix 2).

The findings of the project will also be disseminated through articles in journals related to blindness and services to blind and visually impaired persons and in key gerontology journals. At the completion of this project, articles are in progress.

Chapter 3

OUTCOMES AND FINDINGS

Two hundred and fifty CHRs were trained at project completion, including 20 CHRs who were trained in Oklahoma City, sponsored by the Chickasaw Nation in September 1988. Fifty CHRs were trained during Phase II. The 250 CHRs represent 27 states, including: Maine, Connecticut, New York, North Carolina, Tennessee, Mississippi, Florida, Louisiana, Oklahoma, Nebraska, Michigan, Wisconsin, Minnesota, North Dakota, South Dakota, Montana, Wyoming, Iowa, Colorado, Nevada, New Mexico, Arizona, California, Washington, Oregon, Idaho and Alaska. The CHRs trained represent over 70 tribes (see Appendix W).

Phase I

In order to determine the effectiveness of the training, information gathering and assessment instruments were designed during Phase I and utilized during Phases I and II. These instruments were created to reveal:

1) cultural information about the population being trained,
2) the impact of the training on CHRs,
3) cultural relevance of the curriculum content,
4) feedback regarding teaching methodology and

5) the impact of the training in independent living skills on older American Indians who are visually impaired or blind.

The instruments used included:

1) The CHR Information Form (see Appendix C) (completed on the first day of training)

2) The Pre-Training Test (see Appendix D) (also completed on the first day of training)

3) The Written Curriculum Review (see Appendix G) (completed at the end of the fourth day of training)

4) The Training Program Evaluation (see Appendix H) (completed at the closing session on the fifth day of training)

5) The Post-Training Test (see Appendix K) (completed at the closing session)

6) The first Follow-Up Survey (see Appendix M) (mailed to CHRs three months past training)

7) The Second Follow-up Survey (see Appendix N) (mailed to all CHRs at the completion of Phase II)

8) The On-Site Follow-up Reservation Visits Interview Questions Guide (see Appendix T).

A review of the information and feedback gathered through these instruments follows.

CHR Information Form Responses

In order to assess CHRs' expectations about the training, the following question was asked on the CHR Information Form completed by each trainee during the first day of the training. (This question did not appear on the information form for the first session in Tulsa, but was added immediately thereafter and used for the remaining training sessions.)

"What do you hope to learn during this training?"

The following responses were the most frequently reported:

- the do's and don'ts of working with blind people
- how to teach blind people to do more for themselves
- methods of coping with everyday life as a blind person
- what resources are available to help blind clients
- how to understand blind clients
- how to talk to clients so they will be less fearful about their blindness
- how to prevent blindness among American Indians
- to learn about eye diseases which cause blindness
- how to help once someone has gone blind
- how to help diabetics
- how to help families deal with a blind relative
- how to help families find resources to help their relatives
- how to train family members to help a blind client

These responses gave project staff the clear indication that CHRs had come hoping to learn how to prevent blindness in their

tribes, what positive things they could report back to their tribes to help blind tribal members, especially to improve morale, and how to help blind clients do more for themselves. How to prevent blindness was the most frequently reported response.

The average CHR had little or no understanding of visual impairment other than total blindness and it took considerable effort on the part of project staff to educate trainees that we were also talking about identifying and assisting visually impaired persons, frequently referred to as low vision, as well as totally blind clients.

Project staff asked CHRs during the first sessions whether or not they had any blind or visually impaired clients in their caseload. Only one or two members of each class of 35-40 replied that there were blind or visually impaired clients on their caseload. It was always a totally blind or "almost totally blind" client who was identified.

When asked the same question at the end of the last component of the training sessions, over half of the class indicated that they had "visually impaired" or "low vision" clients in their caseload. It can, therefore, be concluded that the training had assisted CHRs in knowing who could benefit from rehabilitation services, particularly through the use of low vision aids, low vision adaptive equipment and environmental adaptations.

Findings of Interest

The Pre-Training Attitude Test

The pre-training test administered during the first session of training was used to give trainers a sense of CHRs' attitudes about blindness, blind people, and an understanding of the kinds of things blind people can and cannot do.

The same test was administered as a post-test during the closing session to determine the impact of the training session on attitude change and knowledge gained. The post-test demonstrated a dramatic positive change to such statements as:

1) A blind person can never be happy;
2) Blind people can be taught to do most of the things they were doing prior to blindness;
3) Most blind people think and act alike;
4) Blind people should be given a pension to live on disability without working; and
5) Blind people have as many interests as sighted people.

The Issue of Independence/Interdependence

A major focus on functioning in this country speaks to the issue of independence. Rehabilitation for a disability is to restore the individual to his/her own level of independent functioning. The focus is on the individual. Independent living skills training implies helping the disabled person, in this case the older visually impaired person to function as independently as possible and as independently as he/she wishes. Through the

literature, trainers of the American Indian project were aware that the goal of being able to do more or to have functioning restored focused more extensively on being able to function interdependently within the family and tribe than independently for the American Indian. This was reinforced through the training.

Within the culture of many tribes the major focus of working and living together is on interdependence among members of the family unit and tribe. The use of the word interdependence as well as independence as a goal in our discussions helped to present the curriculum as more culturally appropriate to trainees. Therefore, independent living skills for greater interdependence will assume a fuller flavor of American Indian culture. This perspective has been incorporated into the model curriculum throughout but particularly in the module on daily living skills training.

CHRs also reported that the introduction of change and new ideas presented a concern on some levels related to the training. While varying from tribe to tribe, many CHRs felt that tribal politics set the standard for a particular line of thinking and actions, indicating that it would be important to also educate tribal leaders about what they had learned. It was clear that in order to have the greatest impact on the individual visually impaired person and his/her family members, the elders in political positions would need to understand and support their efforts. CHRs, therefore, have a larger job within their tribe

than originally understood and, based on their position in the tribe on their reservation, will have greater or lesser impact on the extent to which project teachings are implemented and valued.

Findings Related to the Psychosocial Aspects of Aging and Vision Loss

Throughout discussions with CHRs during Module IV, The Psychosocial Aspects of Aging and Vision Loss, the following psychosocial issues were identified as those interfering with the acceptance of vision loss among elderly American Indians as identified by CHR trainees. Many American Indian elders:

- think their eyes will get better
- feel their vision loss is the result of ill deeds or thoughts or the breaking of a traditional taboo
- seek only the medical advice of the medicine man or shaman for cultural remedies familiar to them
- fear surgical procedures and refuse medical assistance even when available to them
- ignore a physician's advice
- cannot learn to deal with what they can no longer do in carrying out their activities of daily living
- are fearful of unfamiliar environments
- are fearful of being a burden to their families so they frequently do not ask for the help they need from their families even when it is readily available

- o want to be independent and feel they will never have a chance to be independent again
- o want to be able to assume their interdependent role within the family or tribe
- o are fearful of staying alone once they lose their vision.

Many of these fears are the same as those experienced across cultures, but the impact of American Indian cultural thinking cannot be overlooked.

Curriculum Component on Recreation and Leisure Activities

Project staff were particularly interested in learning the cultural application of this material to CHRs. Rather than teach this component in lecture form, professional staff asked CHRs to work in small groups to come up with lists of traditional, leisure and recreation activities for discussion and to consider whether visual impairment interferes with an elder's participation in that activity and what would need modification for elders to continue to be able to do the activity.

A list of all the activities mentioned in each of the training sessions is listed below.

bingo
checkers
ceramics
basket making
beadwork

sewing

cooking

religious activity

cherry picking

going to pow-wows

visiting other reservations

going to Native dances

trips

concerts

square dancing

picnics

nature walks

rummage sales

bake sales

joining an Indian club

fundraising for arts and crafts

becoming a foster grandparent

speaking at career days for youths

going to elder/youth conferences

Most CHRs felt that if an elder wants to continue to do a task or activity, family members and members of the tribe find a means by which to assist, especially in the area of traditional, cultural, religious and tribal activities. CHRs feel there is a strong focus on absorbing the disabled individual into the routine scheme of things despite age or ability and that the value of the individual is seen before the disability.

For example, an 84-year-old blind woman wanted to continue her favorite activity, sewing, but was not able to thread a needle. In order to help her continue a valued pastime, her daughter came to her home each evening to thread 20-25 needles so her mother could continue to sew the next day. The CHR was eager to introduce self-threading needles to the client so she could do this task independently.

Use of the Blindfold in Simulation Exercises

In order to learn and practice a new skill, such as sighted guide technique or to simulate a situation to sensitize trainees to the experiences of their blind clients, such as eating a meal under blindfold, blindfolds were used. CHRs worked in pairs, one blindfolded as the client and the other not, serving as the worker/teacher.

After trainees had participated in many blindfolded exercises, a few explained that within tribal thinking to wear the blindfold was considered "mocking" or "making fun of" a blind person. Trainees presented examples, such as on their reservation in order to practice for a disaster, eight people simulated a disaster exercise drill, which was soon followed by a real disaster involving the same number of people. This occurrence reinforced the belief that to conduct a mock exercise would result in bringing about the condition to one's self, to one's family members and to the tribe. This made several

trainees uncomfortable with simulation activities; however, no one commented on this until the simulation session was ended.

This experience provided the trainers the opportunity to understand the nature of this situation for some American Indians and to decide to make the use of occluders or simulators an optional learning exercise for trainees. It was quite clear throughout the course of the training, however, that a large majority of CHRs were able to separate out the use of blindfolds as instructional rather than "mocking". Most viewed simulation exercises as a training strategy and recommended that the project trainers not eliminate it from their teaching methods, but rather discuss their value as a learning tool with future classes and allow each trainee to decide as to its appropriateness. Throughout the training some CHRs found it difficult to remain under blindfold for very long and, therefore, removed the blindfold when their discomfort level rose.

Alterations in Teaching Methods

Of interest is the change in teaching methodology which was important in teaching some of the modules such as the psychosocial and recreation and leisure modules. For example, project staff originally taught the psychosocial component from the perspective of the experience of older persons with whom they had worked. It became clear early-on that the experience of aging and/or disability was not experienced with the same amount of stress as we know it. When this module's content was presented

from the Anglo perspective, the instructor was met with blank stares and no participant response or interactions. Rather than "presenting information" on the psychosocial aspects of aging and vision loss, project staff conducted this training component by having small groups of CHRs discuss this topic, make lists of feelings of loss or reactions among individuals and family members, and then report to the larger group for further discussion and summation. The change in methodology allowed CHRs to express feelings and reactions which were, in fact, similar to Anglo elderly.

Concrete Problems Confronting American Indian Elders Experiencing Visual Impairment

CHRs identified some of the major concrete problems confronting elderly blind and/or visually impaired American Indians in their day-to-day activities:

- no transportation is available to get to needed services, where services exist
- it is difficult to shop for necessary items, particularly food, because of geographic barriers
- it is difficult to cook and clean independently for one's self or family members
- it is difficult to select clothing and care for clothing when spotted or soiled

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- o it is not possible to identify medications independently and, therefore, difficult to self-medicate
- o it is difficult to get bills paid
- o it is no longer possible to enjoy crafts or other leisure time activities without vision
- o there are no opportunities for early diagnosis of eye conditions for many American Indians or to prevent gradually deteriorating conditions
- o in many cases there is little or no help available to carry out daily tasks even semi-independently
- o there is little community support outside the family, in some cases.

These findings indicate that vision loss has the same impact on the older person experiencing vision problems across cultures.

CHRs Perception of Cultural Application of New Skills

On the fourth day of training, small group discussions were held to review the cultural application of skills learned during the training in their work with clients. These groups were typically held immediately prior to the written curriculum review. Applications included:

- o encourage client to maintain physical activity by using sighted guide
- o encourage clients and family members to monitor eye conditions by keeping ophthalmology appointments

- o work with the client to organize household items by labeling methods learned and, in particular, label medications for independent dispensing
- o work on cooking skills
- o encourage the teaching of sighted guide to family members or others for more independent functioning
- o teach an adaptation to bingo in order that a visually impaired client can participate in an on-going tribal pastime
- o observe symptoms of low vision among clients and support modifications and adaptations to the physical environment in order to make the environment maximally client-friendly.

Small group discussions provided CHRs with the opportunity to learn from each other as well as the instructors. It also gave instructors the chance to hear American Indian perspectives with regard to cultural application.

Strategies for Sharing Learning, Post-Training

Small groups were also asked to work together to discuss how they might use their learning to transfer information and skills to other workers on the reservations. Participants discussed possible in-service training sessions and participation in health fairs. The most frequently mentioned strategies included this list of possible further efforts:

- . share with colleagues informally

- report to supervisors and other staff at formal staff meetings

  (Most CHRs who participated were expected to report back at a staff meeting and to share literature and materials received at the training.)
- send articles to tribal papers
- offer in-service workshops
- encourage identification of low vision clients of all ages among all CHRs
- make clients more aware of their own needs regarding vision and of resources available in their region
- enlist optometrists/nurses and other health professionals to ensure care
- work with the IHS to create linkages with blindness organizations in their region to increase client access when visually impaired elders want additional training
- develop advocacy techniques to use within their own program to get general services for clients and from blindness agencies
- work with health boards in their area to promote vision screening for early low vision detection
- encourage all CHRs to become knowledgeable of resources for the blind and visually impaired and to create linkages with these agencies
- conduct public education programs

A Mutual Learning Process

The training project afforded staff many opportunities to exchange information with CHRs, as well as opportunities for CHRs to share information with each other regarding service delivery to older blind and visually impaired American Indians.

According to CHRs involved in this project, health care poses a particular problem for American Indians. Almost all health needs are taken care of by the IHS facilities. The types of medical services available, the sophistication of these services and the ability to access these services varied widely from area to area and from reservation to reservation. From the CHRs' perspective, eye care appears to be given a lower priority in general and especially for older persons. CHRs recounted situations of people losing their vision as a result of glaucoma, cataracts and diabetic retinopathy. In many areas there is limited access to an ophthalmologist. In most communities, a request for an ophthalmological evaluation comes from the general physician. This physician may not always know the urgency or the importance of immediate intervention and ongoing care related to eye conditions. The situation is magnified, according to CHRs, by the fact that even when appropriate intervention is available and obtained, many of the older American Indians refuse to follow a physician's orders or take the prescribed medication because it goes against cultural beliefs. Even when services exist, many elders prefer to live as they are and accept their disability. Many elders do not want to deal with someone other than the

traditional shaman or medicine man. This is most especially true if the ophthalmologist is Anglo. Many elders subscribe to a cultural belief system that prevents them from going to or receiving treatment from anyone who is not a traditional shaman or medicine man. There is often a belief among some of the elders that if vision is decreasing or if an individual goes blind, this is the result of some earlier offense and, therefore, it is to be endured.

Overall, the ways by which older American Indians respond to vision loss is similar to reactions demonstrated by the Anglo older people. Feelings, emotions and reactions vary from individual to individual, from tribe to tribe and from region to region. When asking a group of CHRs to describe the way in which their older clients react to vision loss, CHRs use such descriptors as "angry", "frustrated", "depressed", "afraid", "worried", "anxious" and "frightened". Some older American Indians become reclusive, not wanting help or assistance. Others become overly independent, wanting to do everything on their own. Still others are very open to help and suggested strategies and functional skills to apply while performing activities of daily living. All these reactions are common among the general population of older persons experiencing vision loss or other losses and disabilities. There is, however, less verbal expression of intense feelings unless solicited.

Culturally Appropriate Interaction and Communication Patterns

Project staff were aware of the differences in cultural patterns of interaction among Native Americans. Actual interactions for the most part supported the patterns reported in the literature. Project staff used their experiences to measure the application of norms portrayed in the literature.

Orlansky and Trap (1987) make specific recommendations for non-Native American professionals in developing effective patterns of communication and interactions with disabled Native American students, clients and their family members.

They recommend the following to teachers of Native Americans:

1) Do not expect direct eye contact. Although non-Native Americans typically attach great importance to maintaining eye contact while conversing with others, many Native Americans avoid it. Directing one's eyes downward when listening to a teacher or counselor may be a sign of respect, rather than of inattentiveness. In Bayne's (1971, p. 33) view, the avoidance of eye contact is one way of assuring that "each individual may have the privacy of his own thoughts and expression without the intrusiveness of someone else's emotional reactions." In spite of this cultural pattern, trainers by their nature sought eye contact with CHRs particularly in the early sessions, to get a sense of whether or not the material was clear and whether the teaching methods were appropriate. Some CHRs made eye contact in response, which helped the instructors.

2) Do not probe deeply. The concern for emotional privacy also makes it inadvisable to ask questions that delve into the client's private life and feelings because such questions are likely to be considered an unwelcome intrusion. Conversely, it is improbable that Native American clients will be eager to inquire about the professional's life and feelings. Professionals who attempt to establish rapport by engaging in extensive emotional self-revelation risk losing credibility and trust. Many CHRs were able to volunteer to speak about family reactions to vision loss or another disability when questions relating to these issues were raised by the audience in general. It is probable that the emotional issues involved made role playing uncomfortable for some classes while others responded positively.

3) Develop a tolerance for silence. Long periods of silence tend to make non-Native Americans uncomfortable, nervous and anxious to "break" the silence. In many Native American cultures, however, silence conveys a sense of "oneness". Filling the air with continuous conversation is seen as inappropriate.

4) Do not reprimand or praise a Native American in front of others. Such behavior may well be regarded as a violation of the individual's pride and dignity. Private and quiet settings should be used to communicate disapproval. Similarly, professionals who make conspicuous use of public praise and rewards may unintentionally embarrass the recipient of these accolades.

5) Make your handshake gentle. Native Americans do not like excessively firm or vigorous handshakes. In addition, Richardson (1981) suggested that when a professional greets a Native American client in the office, it is considered polite to offer food or a beverage, such as a glass of water or a cup of coffee.

6) Use demonstrations of actual skills or techniques. Demonstrations are preferable to verbal commands or instructions. As Pepper (1976) pointed out, Native Americans are usually not impressed by one's social status, academic credentials or professional titles because they judge a person according to what he or she does. Thus, modeling and observation may be an effective instructional approach in many cases. Furthermore, academic experience is considered by many Native Americans to hinge on individual "Indian" life experiences. Native American youths frequently like to identify with others who are their age and who have had similar experiences. Therefore, tutoring by peers is a viable instructional method for American Indians. It is because of these cultural implications that instructors paired students off to take turns in the teaching and learning of each of the daily living skills as well as sighted guide.

7) Respect the importance of the extended family. In contrast to the isolation and rejection often experienced by elderly people in mainstream America, elderly American Indians are usually respected members of the household and tribe because of the wisdom and experience which come with advanced age. For this

reason, the project focused on family involvement in the rehabilitation process.

Project staff respected these cultural patterns of interacting, and used them as a guide in working with participants. It was most clear in our experience that doing and demonstrating was a superior teaching method to discussion and description of a skill to be acquired. Observing CHRs teaching each other was the best indicator of success of the training.

Each class also had its own character. Quiet classes were difficult, but the instructors who valued discussion and questioning understood this was not the cultural mode. Lack of eye contact was probably even more difficult, or the lack of nodding one's head in acknowledgement or recognition. Over time, instructors learned to reassess successes, particularly by observing the investment in hands-on learning experiences by CHRs.

As mentioned above, not all classes were interested in role playing. Instructors had anticipated this, but the first class was extremely responsive and participated wholeheartedly. The first class was not representative of the CHRs taught, however. It was the only class where 92 percent of the CHRs lived off the reservation. What worked there needed to be modified for the next class of reservation CHRs. CHRs who lived and worked on the reservation represented 85 percent of those trained.

CHRs as Family Members

A significant result of the project which had a strong focus on family rehabilitation was the fact that by training CHRs we were also training family members about blindness and visual impairment and the types of adaptive techniques which can be employed to carry out activities of daily living more independently. Many CHRs invested both personal and professional energy into the learning of this training program because they had a blind or visually impaired immediate family member, parent or grandparent or other relative. As CHRs were asked to think of a client in their caseload who was visually impaired whom they might be able to assist when they returned to their position, many could not think of a client but used a family member or acquaintance as their reference point. As CHRs, and family members, they will hopefully impart some of their learning to other family members so that both the visually impaired individual and family can benefit.

Family Involvement

Family members play a very important role in the coping process for newly blinded and low vision persons, according to CHRs trained by this project. Most of the CHRs, when talking about family reactions to their elder family member's blindness or visual impairment, said that family members tended to be overprotective, preferring to "do for", rather than allowing or encouraging the individual to do for him/herself. In some

instances the family would ignore the elder, not wanting to become involved or deal with the problems which surround vision loss. In some cases, situations of neglect and/or abuse were described, particularly in the area of financial abuse of a frail or disabled elder. There were no reports of any physical abuse mentioned by CHRs, though it is significant that the IHS CHR Program has recognized elder abuse within the culture and offers a "specialty training" on this topic for CHRs.

CHRs in general felt strongly that family members would better cope if given information concerning a disability such as visual impairment or blindness. Skills that could be learned, ways by which family members could assist the blind or visually impaired family member, and the opportunity to observe the blind or visually impaired elders learning to function safely and with greater independence, would be helpful to family members in coping with stressful situations. Learning new skills for daily functioning, in particular, helps family members view older persons as an integral interdependent part of family and reservation life. CHRs stated that many elders and their families need to continue their own methods of functioning related to vision loss even when new strategies would be taught by CHRs.

Frequently CHRs described elders as living alone and facing many of the same problems as Anglo elders, and facing some of the same societal changes as the rest of the population. Many younger people are leaving the reservation to look for employment and to try to assimilate into the mainstream of American life.

This leaves American Indian elders in the same situation as those elders in the general population who have lost geographic proximity to children and grandchildren. Many older CHRs expressed concern that children and young adults are no longer interested in learning their native language or in following many of their American Indian traditions. They report that Indian crafts are suffering as a result of this. Young adults do not want to learn beading, weaving, leather work or other handcraft. Many described the younger generation as not having the same kind of respect for the older generation as it did when culture and language were the foundation of family and community life. Many CHRs believe that the high incidence of alcoholism among the young American Indian population is having a strong negative impact on family life structure. Alcoholism is another IHS specialty training priority. These descriptions indicated that the image of extended family life on the reservation is not necessarily the norm and in the '90s is more myth than reality among some tribes.

The Training Program Evaluation

On the last day of the training sessions, trainees were asked to complete a Training Program Evaluation. The evaluation served to give trainees an opportunity to let the trainers know how they had experienced the training from a cultural perspective, how they learned best (by which teaching methods) and provided feedback on an array of ways in which trainers could

modify the training both in content and method for the next class in order to provide the most effective teaching for American Indians, as well as produce a culturally appropriate model curriculum as an end-product of the project.

All trainees expressed the feeling that they had learned from the training, that at the very least the training had:

1) sensitized them to the issues of aging and vision loss,
2) heightened their level of awareness about blindness and visual impairment and its prevalence,
3) changed their attitudes and perspectives toward visually impaired persons, and
4) learned skills which they could teach to clients and family members of visually impaired elders.

Many suggestions were made for change or modification in content and teaching methodology, and information was shared regarding cultural aspects of delivering service and receptivity to service.

Suggestions for change or modification during various points of the training were:

- use less lecture and more demonstration as a teaching method
- provide more hands-on experiences and opportunities for working with other trainees either in pairs or teams during training sessions
- offer more opportunities for learning new skills under occluders or simulators during training sessions

- o give fuller attention to techniques applicable to practices such as cooking on a woodburning stove rather than gas or electric
- o offer all trainees the choice to either use or not use occluders in order not to infringe on any cultural line of thinking
- o build in more role playing activities to encourage identification with the issues and feelings of elders who are losing their vision and to address some of the psychosocial aspects of the process of vision loss
- o consider videotaping the curriculum components dealing with learning adapted techniques and skill acquisition for review by the trainees and for future training purposes.

With the exception of videotaping, these suggestions for change were incorporated at various points in the training.

The majority of CHRs indicated that they learned best by doing, that they were unaccustomed to sitting at their jobs but learned through activity. Increasing amounts of time then were devoted to active learning during the training.

The curriculum and teaching methods were modified after each session based on instructors' observations and perceptions of each class and input from trainees. What was so fascinating was that every class was so different and different things worked best for different classes. This helped the instructors to be open and flexible and responsive to the class.

Personal/Professional Impact of the Training

As part of the Training Program Evaluation, CHRs were asked how the training program affected them personally or professionally. The following primary areas of learning were most frequently reported by CHRs at the end of the five-day training session. These most frequently reported responses complement those identified on the CHR Information Form in response to the question, "What do you hope to learn?"

1. The training program on aging and vision and techniques of daily living changed my attitude toward blind people.
2. The training gave me a better insight into the experience of blindness or severe visual impairment; "it opened my eyes" to what a blind person goes through as she/he loses her/his vision and what it's like not to be able to do basic activities.
3. I learned how to approach family members of elderly blind or visually impaired clients, to make family members more aware of their elder's needs for assistance and ways to assist and not to assist, as well as the capabilities of people who are blind or the ability to carry out daily activities if trained in adaptive techniques of daily living activities.
4. I learned that blind people can be useful and independent and that they can be contributing members

of the family, the tribe, and involved in community or reservation life.

5. I learned that a very small change, such as learning a new small skill like a method of using the telephone or identifying paper money, can make a big difference in the life of a blind or visually impaired person.

CHRs anticipated that the following information and skills would be used upon return to the reservation or American Indian community in their work with blind and visually impaired elders on their caseloads. These comments reflect both the personal and professional impact of the project.

1. I will be able to guide patients into and around the health clinic and in and out of the transporting van when I transport them to and from their homes and health care facilities.
2. I will instruct elders how to make the best use of existing lighting in their homes and how to use color contrast in changing the environment so that they can orient themselves more easily to the indoor environment.
3. I will encourage members of my tribe to have regular vision checkups.
4. I will involve the client in the planning of their overall care as a result of this training. I will no longer plan for them.

5. I will try to start a support group for members of the reservation who are blind or visually impaired.
6. I will include more information on preventing blindness and the eye diseases associated with aging during regularly scheduled health promotion activities on my reservation.
7. As a health educator I will try to teach members of my tribe, particularly young children, about blindness and visual impairment, so that attitudes about people who are blind and about blindness will change at an early stage.
8. I will teach the granddaughter of a blind client how to help her grandmother up and down steps by using the sighted guide method. It will help her and her grandmother feel better about themselves.

Other responses to this question include the following:

I learned:

. that the worker needs to be sensitive to the blind person's needs as well as the needs of the family members of a blind client
. a little about how to introduce new information to my client(s) and to family members to bring about change in attitude and activities
. how to guide a blind person, which I can teach to blind clients, to family members of blind clients and to other staff people where I work

- to be more aware of the blind person's ability and desire to make choices for themselves
- about the specific eye conditions which are related to elderly American Indians which can result in severe vision loss or blindness
- skills through simulation exercises and can teach these to family members
- patience and compassion for blind clients, but to not pity them
- that when a client who is blind is able to learn to do a task for him/herself, he/she will feel better and it will enhance self-esteem and self-confidence.

These responses reveal the impact of the five-day training on CHR trainees. They indicate changes in attitude which took place among CHRs, the acquisition of information and knowledge about the meaning and importance of rehabilitation, and the particular significance of the involvement of family members in the rehabilitation process. Their comments indicate that CHRs gained knowledge of: eye diseases, low vision, visual impairment and blindness; the psychological and social issues underlying the experience of vision loss or blindness; local resources, and how to gain access to these resources.

These responses also document the new skills which will be employed upon return to work with clients and family members, and the new techniques learned which the CHR will teach clients and their family members to function as independently and

interdependently as possible.

The Training Project Follow-Up Component

It is important to note that a survey cannot replace first-hand observation by project staff of CHRs working with visually impaired elders. However, it was deemed the most appropriate post-training assessment modality based on cultural needs. Site visit interviews with CHRs on their reservations at the last stage of Phase II gave additional firsthand information about the transferability of learning to teaching clients.

Phase I Follow-Up Survey Results

A follow-up survey was sent to each of the 200 CHRs who participated in Phase I of AFB's American Indian Rehabilitation Project. Surveys were sent three months after the completion of the week-long training of each group of trainees.

- Of the 200 surveys sent to CHR trainees, 82 surveys or 41 percent were returned
- 78 percent of the respondents identified low vision elderly clients in their caseloads
- among the respondents, there were 770 elderly low vision clients of a combined caseload of 8,929 elderly clients
- 8.7 percent of the combined caseloads of elderly clients reported by CHR respondents are blind or visually impaired

- Of the 82 CHR respondents, 72 percent had spoken to their clients about the adapted techniques they learned during the AFB training
- The most frequently reported techniques described and discussed with elderly clients were the following:
    - sighted guide
    - use of the telephone
    - improving lighting conditions
    - money identification
    - safety techniques for cooking
    - protective method for entering and getting out of a vehicle
    - telling time
    - methods of labeling and identifying medications and other household items
    - use of hand-held magnifiers
    - eating skills
    - using adapted sewing items
- 92 percent indicated that they are using sighted guide when walking with clients (75 respondents)
- 92 percent had taught sighted guide to their low vision clients (75 respondents)
- 92 percent (or 75 respondents) have identified low vision services in their area, with a majority identified in Oklahoma and North Dakota

- 89 percent (or 92 respondents) referred clients for low vision services
- 275 clients were referred for low vision services in their region
- 76 percent (or 62 respondents) have developed an adapted recreation or leisure activity with visually impaired elderly clients in their own community
- 92 percent (or 75 respondents) indicated that the curriculum content on the psychosocial aspects of aging and vision loss was helpful
- When asked what type of assistance CHRs and their clients would like and felt were most needed from a local blindness or aging agency, the following responses were reported most frequently:
    - transportation
    - low vision aids
    - help with recreation activities in the home
    - help with household chores

CHRs also reported that they wanted more of the adapted equipment distributed during the training such as Hi Marks, signature guides, telephone dials, playing cards and double spatulas. They also wanted greater availability of rehabilitation teachers in the blindness field so that rehabilitation services could be accessed more readily by American Indians.

While these responses readily indicate the extent of the impact of the CHR training on the CHRs' ability to improve the

quality and quantity of services for the blind and visually impaired elders on their caseloads, the reader must bear in mind that CHRs may interpret questions more loosely than intended. This is particularly true in the area of identification of low vision services and of referrals to low vision services. Since we know the relative scarcity of low vision services available in rural America, it is unlikely that such a high percent of referrals were made to low vision clinics. More likely, visually impaired clients have probably been identified and referred to an IHS facility for visual acuity screening. The CHR has the potential to assist visually impaired clients in access-ing services beyond this point.

While the percentage of respondents' successes is quite high, it is important to bear in mind that those actually using the training with clients have a greater probability of responding. Further results of the second survey conducted at the end of Phase II are discussed at the end of that section.

Phase II, "Training the Trainers"

Conducted in Tucson, Arizona, July 31-August 11, 1989

Designed as a means by which to perpetuate the AFB training model, the "Train the Trainers" session was an effective means of transferring knowledge based on aging and vision loss issues and skills in adaptive techniques for independent living to the Indian Health Service system. Project staff gained invaluable concrete information regarding American Indians, American Indian

elders, the CHR program objectives and operations, the elements which create optimum learning for CHRs, and about the varied roles of professional American Indians who are in teaching and training positions. Newly trained trainers learned a great deal of content and teaching methods effective in teaching others to teach blind and visually impaired elderly persons.

An exhaustive search for the most appropriate professionals to train was conducted by Cheryl LaPointe, Program Analyst and assistant to Nicky Solomon, director of the CHR Program at IHS. Twelve potential candidates were identified and invited to participate, four as alternates. As individuals indicated their inability to attend, alternates were moved up and additional candidates sought. A class of eight with two alternates was identified. Of the final selection of eight professionals to be trained, only seven were able to attend.

Two blind persons were among those selected for the training. A blind Native American from Alaska who had been targeted to become a trainer since the supplemental phase was conceived, could not attend because of time constraints. He was, however, replaced by another Alaskan, P. J. Overholtzer from Anchorage, Alaska. This was important in order to bring instruction to Alaska. She will serve as an excellent trainer resource for Alaska as well as the lower 48 in her daily work and for specialty trainings.

Another of the candidates selected was also blind. He was an American Indian involved in blind rehabilitation. He was

scheduled to attend until the Friday before the training, when his release from work responsibilities for the two-week period was revoked. Massive quantities of printed training materials had been reprinted in braille by AFB and all writing equipment borrowed for his use from the Tucson Association for the Blind. It was impossible to replace the eighth trainer with no notice.

Two full days of training took place at the Tucson Association for the Blind and Visually Impaired, which loaned AFB its daily living skills training facility. New trainers worked in pairs, teaching each other all the skills outlined in Module V. NBC's KVOA-TV in Tucson provided television news coverage of the AFB "Train the Trainers" session on the five o'clock edition of the evening news on August 4, 1989.

Limitation of the Train the Trainers Session

One difficulty in the two-week training of the new trainers was that not all trainers could stay for the full two weeks. By project plan, the two weeks provided one week of training to the trainers, with the second week to serve as the practicum during which time the trainers taught a class of 28 CHRs. Teaching experience during the practicum was essential to be qualified to teach future five-day specialty trainings to be conducted by IHS and IHS staff and/or consultants. Of seven trainers, three could not participate in the practicum during the second week.

As a result, the project director and the rehabilitation instructor devised two possible alternative to the certification of new trainers:

1. Those who remained for the second week and taught the class of 30 CHRs (their practicum) were qualified to teach the week-long "specialty trainings" to be conducted by IHS in the future. Those who had to leave at the end of the first week were certified to teach the four-hour component of the seven module curriculum to be included in basic training, but were not qualified to teach the week-long specialty training.
2. If any of the three trainers who could only attend one week could be involved in the planned Alaskan training eventually moved to Portland, this would serve as their practicum.

One additional trainer was certified after co-teaching the Portland, Oregon class in January 1990, which brought the total to five qualified to teach the week-long training. One additional trainer will hopefully be certified after completing his practicum during the first specialty training conducted under IHS auspices.

Project Staff Perspectives on the Trainers Teaching CHRs

The trainers-to-be held Masters degrees and were experienced in organizing, teaching materials, leading discussions and directing and instructing CHRs. It was possible for project

staff to relate to them and communicate with them with ease from the outset. All new trainers had excellent written and spoken language skills and used current professional jargon, which eased the process of establishing good working relationships. They were attuned to the roles and responsibilities of the community health representatives (CHRs) whom they train, and to teaching methods utilized in this project.

The new trainers became seriously involved in their own learning opportunities and participated actively in discussions with trainers and among themselves. They responded readily to all assignments, including reading autobiographies of blind persons. Required reading materials had been sent to the new trainers prior to training. Unfortunately, time did not permit them to take advantage of supplementary literature which we provided to enable them to acquire depth and breadth regarding visual impairment. Because of time constraints several resource books were purchased with grant funds and sent to the new trainers during the last stages of Phase II. These will assist the trainers in future trainings to be conducted by IHS.

During the second week of the Tucson training session, four trainers were responsible for teaching a class of 30 CHRs. They were: Madonna Blue Horse Beard of South Dakota, Cheryl LaPointe of Washington, D.C., P. J. Overholtzer of Anchorage, Alaska and Myrtle Patterson of Oklahoma. From the beginning they assumed responsibility for planning and their individual responsibilities for teaching the modules or components of the modules. Team

teaching took place, and each instructor took the responsibility for planning and teaching specific modules. They depended very heavily on the written curriculum as it existed, while trying to develop their skills in teaching this new content.

The content taught by the new trainers included a focus on aging and vision loss curriculum but also included a strong emphasis on safety in the home. This was a major focus at IHS because of some of the poor living conditions of many elders' environments. Vision loss presented an additional safety issue.

The new trainers also taught "for the test", i.e. they repeated and reinforced the primary learnings which they knew appeared on the final written curriculum review. This represents the teaching method used in the CHR basic training program. They offered less of the background material regarding the project and less information related to learning, per se, and more on the concrete information and skill development. In small group discussions in which the goal was to acquire information from CHRs, the trainers were active contributors rather than remaining within the role of instructor and facilitating participation by CHRs.

The trainers made extensive use of visual materials in their presentations, including overhead, chalkboard or flipchart. The content and method adjustments were intrinsic to IHS training style.

The impression of project staff is that the fact the trainers were American Indians made a difference in the following ways:

- Trainers were familiar with CHRs' work roles and identified with them culturally. Some knew some of the students from the three-week basic training sessions.
- Trainers were familiar with the instructional patterns of CHR training sessions conducted by IHS, how CHRs learned best, and how long they could tolerate lecture versus hands-on learning experiences.

While project staff felt they had learned much about these issues throughout their experiences with the project, to these trainers it was second nature. They were better able to differentiate among spiritual, cultural and recreational activities; this helped project staff refine the leisure time component of the curriculum to make it more culturally relevant. Their use of humor also helped to establish rapport from the outset. They conducted an evening session the first night for the purpose of getting to know each other through "getting to know you" activities. They became a teaching and learning team, which contributed to the positive atmosphere for learning.

Project staff Ruth Kaarlela and Alberta L. Orr observed their teaching and provided feedback after sessions, rather than interrupt for clarification or additional information. After each training day trainers and project staff met to review the

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day, to critique teaching methods and content from each other and from project staff.

Criteria for Trainer Certification

During the two-week training period, which included one full week of teaching a class of CHRs, each trainer had to meet the following qualifying criteria:

1) Prepare a lesson plan for teaching a skill. The lesson plan included: content to be covered, teaching method(s), materials required to teach a skill, learning activity planned, after-session learning activity assignment, reading assignment.
2) Teach a skill area to the professional trainers individually.
3) Complete a written qualifying exam.
4) Evaluate the training curriculum for cultural relevance and make all necessary modifications, corrections and additions required.
5) Teach 2 to 3 components of the curriculum to the class of 30 CHRs.
6) Describe and demonstrate to the class an adaptive technique and its skill instruction. Each selected a skill from a list of 12 skill areas.
7) Read an autobiography and participate in a discussion regarding the following features of the autobiography:

a) What was the significance of blindness to the individual?

b) How did he/she cope?

c) How did blindness affect relationships with family and significant others?

d) How satisfactorily do you feel the individual learned to live with his/her visual impairment?

e) What were the strengths/positive factors and the limitations/negative factors associated with the individual?

By the end of the two-week training session, four trainers were qualified to teach the specialty training on aging and vision loss. One additional trainer met the qualifications during the January 1990 CHR class conducted in Portland, Oregon. One trainer plans to complete the requirements for certification when IHS conducts its first specialty training on aging and vision loss, and one trainer is no longer involved in Indian services.

Training Conducted by New Trainer, Post-Tucson Experience

In October 1989, Myrtle Patterson, the newly-trained trainer from Oklahoma, conducted a two-day training for CHRs covering several components of the AFB curriculum including:

- Introduction to Rehabilitation
- Understanding Low Vision
- Sighted Guide/Walking in Familiar Environment

. Independent Living Skills Training

Twenty CHRs attended the training. With little or no budget for this effort, Ms. Patterson xeroxed many of the materials for distribution to the class.

Ms. Patterson, as a health educator, has also included information regarding eye care and rehabilitation services for the visually impaired in her health education activities in general. In this way she has proved to be an excellent professional to have been trained since she has incorporated her learning regarding aging and vision loss into her routine work role.

In the spring of 1990 a CHR three-week basic training session was held in Albuquerque, New Mexico, under the coordination of Mr. Tony Padilla, the CHR Area Coordinator of the Albuquerque IHS Region. Mr. Padilla contacted Ms. Vonnie Haggins, one of the new trainers, to teach the four hour component on aging and vision loss. This represents the first official step taken by IHS toward the goal of having aging and vision loss content in all future basic training sessions.

Phase II, CHR Training Session

Before describing the events and outcome of the final CHR training, some information about the need for a training session in Alaska is necessary.

Alaska Training Needs

Discussion of the special need to train CHRs in Alaska arose at the first meeting of the National Advisory Committee to the American Indian Project in November 1987, two months after the project was funded.

Nicky Solomon, the director of the CHR Program, presented the need to train CHRs in bush areas in Alaska because they are far removed from services. This group of CHRs was also described as "being overlooked" and having little access to any type of training. It was determined at that time that, should additional funds become available, Alaskan CHRs would be a top priority.

When a request was made to conduct Phase II of the project, training a class of 20 CHRs in Anchorage was proposed and accepted as a project priority by the Administration on Aging. When it was time to plan for the Alaskan training session, several obstacles arose:

- The first was an issue of when to schedule the class because of a high level of activity in Alaska during the time originally planned in the proposal (i.e., summer fishing months, state conferences and local training sessions).
- The second was a question of what CHR-related staff person would have time to coordinate the details of arrangements for the training with the project director.

. The third and most pressing issue was one of "who" to train.

Two groups of paraprofessional service providers exist in Alaska: Community Health Representatives (CHRs) and Community Health Aid Practitioners (CHAPs). CHAPs provide a higher level of health care and their training is more extensive. A difference of opinion existed within IHS as to whom to serve. Since Community Health Representative program dollars were to serve as part of the IHS matching funds to the project related to the Alaska training, it was deemed most appropriate by IHS to train CHRs.

When the "call for participants" was sent out, the names of only seven CHRs were submitted. Since this was not enough to warrant bringing training to Alaska, the training site was moved down to the "lower 48", to Portland, Oregon, and the interested CHRs were invited to attend. Only three of the seven participated, bringing the total number of Alaskan Natives trained to five. (One had come to Albuquerque, New Mexico and one to San Francisco, California.)

It is difficult to determine whether the project met the actual needs of the CHR population in Alaska, but the need may have been different than originally described.

After the project director initiated contact with CHR coordinating staff in Alaska, written communication followed from Alaska indicating that "blindness" was not a problem among Native Americans in Alaska to the extent that it is among American

Indians in the lower 48. The need to bring training to Alaska was questioned.

Several factors could have been operating. First is that IHS personnel thought the training was related to persons who were totally blind, when in fact it related to those who were visually impaired as well.

Second, the need to train Alaskan CHRs in this area was probably misidentified. The CHR program, recognizing their own inability to provide as much training in Alaska as in the lower 48, thought the AFB training was an excellent opportunity to serve Alaska. In fact, when the AFB project was developed in 1986 there had been little CHR specialty training for eight years, due to financial constraints.

Third, it may have been beneficial to conduct a class in Alaska for both CHRs, CHAPs and other service providers such as personnel from optometric programs. However, this could only have been accomplished with considerable negotiating and planning on the part of IHS' CHR program staff. Should any additional training be conducted in Alaska, class composition should extend beyond CHRs to maximize the potential for those working in eye care services to gain further understanding of the content of the training curriculum.

Most importantly, however, those Alaskan CHRs who did receive the training felt they were returning home with a wealth of information. Three of the five who attended were in supervisory positions and one of the new trainers was from Alaska.

Those trained have a great deal of potential to share the knowledge learned and skills acquired with others providing health care services to elderly Alaskan Natives.

Infusion of Aging and Vision Loss Content Into the 3-Week CHR Basic Training Curriculum

A project priority was to develop a means by which all new CHRs would be introduced to information regarding aging and vision loss. The most effective means to ensure this was to incorporate a four hour component of the specialty training into the required IHS curriculum.

It was fortunate that the CHR 3-week Basic Training Curriculum was being revised during the course of the project in the summer of 1989. This allowed AFB a greater opportunity to influence IHS about the importance of including a four-hour component on aging and vision loss into the CHR basic training curriculum.

It is important to note that AFB's original conceptualization of the project was to develop curriculum for inclusion in basic training for all new CHRs and to develop in-service training for existing CHRs, the specialty training. At the time of the initial discussion prior to proposal submission, the director of the CHR Program felt that CHR basic training was already overloaded and could not accommodate additional content material. After the completion of Phase I and the positive response from CHR program coordinators and CHRs themselves, IHS

reorganized the value of aging and vision loss content to the CHR Program.

The project director worked with Dorothy Wombalt, the CHAP area coordinator in Anchorage, Alaska who had primary responsibility for revision. AFB project staff developed the four hour component.

The Four Hour Component for CHR Basic Training

I Introduction to Rehabilitation

II Understanding Blindness and Low Vision

III Walking in a Familiar Environment

IV Communication Skills

V Daily Living Skills

VI Resources and Advocacy

(See Appendix S)

After the "Train the Trainers" session in August 1989, P. J. Overholtzer, one of the new trainers who worked in Anchorage, was instrumental in working on the four hour component with Ms. Wombalt. At the completion of the project the revision of the basic curriculum was still being developed in its final form, but there is assurance from IHS that the four hour component will be incorporated. The infusion of aging and vision loss content has the greatest chance of having the most far-reaching and long-lasting impact upon CHRs.

Results of the Second Follow-Up Survey

The second follow-up survey was sent to all 250 CHRs who participated in the AFB training program. It was sent in March 1990 and provided information from CHRs trained during the seven AoA funded training sessions. In order to achieve a statistically significant response, the survey was sent twice.

Of the 250 surveys sent, 99 surveys were returned after the second mailing, for a 40 percent response rate.

The distribution of returned surveys from each of the classes was as follows:

14 from the Tulsa, Oklahoma class, December 1987

16 from the Albuquerque, New Mexico class, February 1988

13 from the San Francisco, California class, April 1988

17 from the Albuquerque, New Mexico class, June 1988

10 from the Bismarck, North Dakota class, August 1988

15 from the Tucson, Arizona class, August 1989

14 from the Portland, Oregon class, January 1990

It is interesting to note that time between training and the survey appeared to have no bearing on response rate.

1) 62 percent, or 61, of the respondents reported that there were visually impaired clients in their caseload.
2) 7 respondents reported having no visually impaired clients.
3) 24 of the CHR respondents reported having no caseload. After the on-site reservation visits the principal investigator learned that the response typically meant that

those CHRs worked as health educators and did not carry caseloads.

Although project staff learned that CHRs held other types of positions other than carrying conventional caseloads, it was not clear whether these CHRs had any caseload at all.

Seven surveys were returned as undeliverable.

4) The mean number of visually impaired clients in a caseload reported on this survey was 6.5 elderly individuals for a total of 397 visually impaired elders in the combined caseloads of 61 CHRs.

5) These CHRs represented a combined caseload of 3,979 elderly persons.

In response to the question, "Have you talked with visually impaired clients about techniques you learned in the training?"

38 said yes

7 indicated that they had not

54 did not answer

Among those who had spoken with clients, 458 clients had been spoken to or an average of 12 clients per CHR.

6) When asked which techniques they discussed, CHRs reported the following:

Sighted guide skills

Cooking, housekeeping, eating skills

Adapted telephone dials

Money identification

The use of Hi-Marks on stoves

Labeling and identification of household and personal items

Personal grooming

Communication skills

Use of the cane

Cards and board games

Self-threading needles

Services for the blind and resources available in the region

Low vision aids - optical and non-optical

Talking Books

Home safety related to visual impairment

Signature guide

Environmental modifications--lighting, color contrast

The need for regular eye exams

7) Respondents indicated that they had taught 297 clients or 65 percent of those informed about techniques

8) 30 CHRs had also taught techniques to family members

11 reported they had not worked with family members on adapted techniques

58 did not respond

9) 22 CHRs indicated that they had referred clients to agencies for the blind for services

17 had not

60 did not respond

10) No one answered the question "To what agency for the blind were elderly clients referred?"

11) 56 CHRs indicated that they knew where an agency for the blind was located in their service area

12) When asked which skills learned were most useful in the CHRs' work with elderly clients, the following top ten skills were indicated and are presented in descending order:

Low vision communication devices

Telephone dialing

Money identification

Labeling and identifying items

Eating skills

Telling time

Cleaning

Kitchen skills (cutting and paring)

Using adapted sewing items

Using signature guide

13) 67 CHRs indicated they were using sighted guides with visually impaired clients

14) 30 had taught sighted guide to clients to use with others

15) 30 had taught sighted guide to family members

16) 21 CHRs said they knew where low vision services were in their region

17) 18 had referred clients to low vision services
the 18 respondents had referred a combined 104 elderly American Indians

18) 18 reported assisting a visually impaired client in adapting a cultural, traditional, recreational or leisure activity

19) 53 CHRs indicated that the psychological component had been helpful in understanding clients' reactions to vision loss
28 said this component also helped to understand family members' reactions

20) CHRs indicated that they had made use of the adapted materials we had distributed during the training session
61 had used Hi-Marks
46 had used signature guides
48 had used playing cards
22 had used telephone dials (most American Indian reservation homes have pushbutton phones)
17 had used double spatulas

21) Those who responded to the question "Which reading materials have been useful, if any?", typically indicated that all reading materials had been useful.

22) Respondents gave the following answers to the question, "<u>If you needed to get assistance from a local agency for the blind</u>, what would you like help with most?"
Sighted guide
Cooking
Transportation
Shopping
Clothing identification
Psychological counseling
Peer support groups
Telephone reassurance service

Where to purchase adapted devices, including:

- Reading lamps
- Magnifiers
- Needle threaders
- Marking appliances
- Clocks
- Cassettes
- More spatulas
- More telephone dials

Financial aid to purchase adapted devices

Speakers for programs in senior centers about vision problems

Talking Books

List of large print books and publishers

Information on Aging and Vision Loss for conference planning

Home delivered meals

Minor home repairs

Legal assistance

Training more outreach counselors in home health care

Having a representative from an agency for the blind come out to talk with clients, informing them of services available through their program

Wider doors for those in wheelchairs

Housing assistance

From this list it is clear that CHRs need a broad array of services for their visually impaired clients, not just those

related to blindness and visual impairment. Many are services available through the aging network as well. It may also be an indication that CHRs believe that agencies for the blind provide all services to the elderly. It is clear that CHRs need help in serving older persons and older disabled persons.

Follow-Up Component: Reservation Site Visits

The follow-up surveys were useful in gathering information about the extent to which CHRs were making use of the knowledge and skills acquired during the week-long training on behalf of their American Indian elderly clients and their family members. Actual interviews with CHRs were key to gleaning the importance and significance of the training to CHRs. Site visits to three reservations were made. All three reservations were in the northwest in the Portland Region of the Indian Health Service. All site visits were within a four-to-five hour drive of each other in order to keep the cost factor of the follow-up component to a minimum.

The three site visits were arranged through the efforts of Ms. Susan Sheoships, the Portland Area Coordinator for the CHR program. Ms. Sheoships had been involved extensively in the selection of CHR participants for several of the training sessions, for much of the local arrangements and class selection for the January 1990 Portland, Oregon training session, and demonstrated a strong commitment to the content of the AFB training program and to the professional development of CHRs. In

keeping with such commitment, Ms. Sheoships accompanied the project director on all three site visits.

The site visits took place in May 1990. Reservations and CHR programs visited included:

Warm Springs Reservation
Warm Springs Confederated Tribes
Indian Health Service
Community Health Representative Program
Warm Springs, Oregon

Yakima Reservation
Yakima Indian Nation
IHS Community Health Representative Program
Toppenish, Washington
Umatilla Reservation
Umatilla Confederated Tribes
IHS Community Health Representative Program
Pendleton, Oregon

The following key CHRs were interviewed during the reservation visits:

Viola Governor, CHR, Warm Springs Confederated Tribes. (CHR trained during the third CHR training session, San Francisco, California, April 1988.)

Clifford Jim, CHR, Yakima Nation. (CHR trained, San Francisco, California, April 1988.)

Barbara Northover, CHR, Yakima Nation. (CHR trained, Portland, Oregon, January 1990.)

Vivian Smartlowit, CHR, Yakima Nation. (CHR trained, Tucson, Arizona, August 1989.)

Tessie Williams, CHR, Umatilla Confederated Tribes. (CHR trained, Portland, Oregon, January 1990.)

Elizabeth Jones, CHR, Umatilla Confederated Tribes. (CHR trained, Tucson, Arizona, August 1989.)

By conducting the site visits in this one region, the principal investigator was able to meet with CHRs trained during three different training sessions during the course of the pro-

ject. These sessions represented the third, sixth and seventh trainings, held in San Francisco, California; Tucson, Arizona and Portland, Oregon respectively. By meeting with CHRs representing various lengths of time since their trainings (April 1988, August 1989 and January 1990), the principal investigator hoped to be able to assess the extent to which those trained two years' ago were still using the training as compared to those more recently trained, and what kinds of programs and services for the blind and visually impaired American Indian were currently underway. At each of the reservations Susan Sheoships and the principal investigator met with trained CHRs, their supervisors and visually impaired clients.

The Yakima CHR program has ten CHRs. The structure and operation of this tribe's program is that each CHR is a "specialist" and, therefore, does not carry a caseload in the traditional sense. Clifford Jim serves as a diabetes specialist. He functions primarily as a health educator, conducting workshops and training for his tribe. His primary thrust, like many CHRs', is in the area of disease prevention and health promotion. As a result of his training, Clifford contacted Viola Governor of Warm Springs. They got together to do workshops on Aging and Vision Loss at health conferences and tribal health fairs. They are an excellent example of the networking of nearby reservations to maximize the knowledge acquired at the training.

Barbara Northover, the most recently trained CHR from the January 1990 Portland, Oregon class, was extremely excited to

share what she had been doing as a result of the training. She, among other things, served as the CHR program's liaison with the Area Agency on Aging's nutrition site program for Yakima elders funded by Title VI of the Older Americans Act. Also in the role of educator she has prepared an array of posters about vision loss, resources and adaptations in leisure, traditional and cultural activities for blind and visually impaired elders. These materials are on display at the nutrition site, but had been borrowed to bring to the site visit. Literature distributed during the training was on display at the nutrition site as a resource. (This is one of the ways many CHRs have opted to share the literature within their tribe.)

Vivian Smartlowit's position is as a "transporter." She is representative of a large number of CHRs whom we trained. This is one of the least valued positions a CHR can hold in the eyes of IHS medical staff. This CHR is viewed only as a conveyance and a cog in the wheel of the medical care system. It has been quite clear throughout our trainings that this role for a CHR is a vital one in providing emotional support to patients as they are transported to medical and social service appointments.

This CHR expressed this extremely well in her description of her job, which she values. She described her role of listener and supporter with various clients who were visually impaired or beginning to have difficulty seeing, whom she had transported to Anglo eye care specialists and to hospitals for cataract surgeries. She told how her role as listener had been expanded as a

result of the AFB training. She was now able to speak to clients about their feelings and reactions with a fuller understanding of what someone losing his/her vision might experience.

While at the Yakima Reservation the principal investigator also had the opportunity to visit the Yakima Cultural Center, Yakima Library and the Yakima Museum. These places demonstrated a wealth of tribal tradition and cultural values.

At Umatilla Ms. Sheoships and the principal investigator had the privilege of speaking to three CHRs, two of whom have been CHRs for twenty-one years, since the program's inception. These two CHRs were significant to the program in their long-term commitment to serving their people. This is particularly true in light of the fact that CHRs today make $11,000 to $13,000 a year. As a result of the low pay there is more turnover in the program than average.

The third CHR, a woman who had only been a CHR for three years, provided transportation to the clinic and the tribe's nutrition site. In general, CHRs took great pride in describing the blind and visually impaired persons on their reservations.

CHRs at Umatilla expressed what appears to be the basic value of the CHR training. When the project was first conceptualized, the greatest value was placed on bringing independent living skills training to CHRs and ultimately to visually impaired Native American elders who were not going to rehabilitation agencies for services. While CHRs value having learned the skills and view them as a great resource which they

can carry with them wherever they go in their work with clients and within their own families, what they value most is the greater understanding they have about the process of losing vision and the kinds of feelings and reactions their clients may be experiencing. Secondly, they value knowing what blindness resources are available to them. While this is not to say that CHRs have not taught skills to clients or have not discussed services with clients.

Site Visit Findings

While follow-up surveys have helped to shed light on the impact of the CHR trainings, the three site visits gave valuable additional meaning to the trainings. During the course of the meeting the following information was gathered:

1. A CHR has, on the average, five to six visually impaired or blind persons on their caseload at a given time.

2. The training helped CHRs identify additional clients who were experiencing problems with their vision whom they had not recognized previously.

3. Content on aging and vision loss issues was more important and valuable to the day-to-day work of a CHR than the actual acquisition of adaptive techniques to daily living activities.

4. Skills taught to individual blind and visually impaired clients helped to improve the safety of the client's home environment. (Environmental safety is an extremely important focus of work on reservations.)

5. Sighted guide was the most frequently taught adaptive technique.

6. Those interviewed were aware of the agency for the blind and visually impaired in their region. Umatilla staff was frequently in touch with the Oregon Commission outstation worker regarding elderly clients' needs.

7. Consumer products given to each CHR for their work with blind and visually impaired clients were either given to individual clients, placed at the nutrition site as a central place for resources for both staff and elders, or were made available at the CHRs' headquarters for general use by all CHRs.

8. Visual impairment does not interfere with the American Indian elder's participation in traditional activities, cultural events or religious ceremonies. Family members ensure the involvement of their family member in significant activities no matter what their disability, if the elder wants to participate.

The interview process helped the principal investigator obtain a fuller understanding of the CHR's perspective of the value and usefulness of the training experience.

It is important to present the current status of the blindness system's outreach and service delivery to older American Indians experiencing vision problems.

Title VII-Part C and American Indian Elders

As mentioned briefly in Chapter 1, half the states in the country are currently receiving Title VII-Part C funding through

the Rehabilitation Services Administration. The federal funds are designated to teach older persons who are visually impaired basic independent living skills and to do so in their own homes and communities. Each of the funded states has targeted their funds to fill in serious gaps in service delivery to older visually impaired persons in their service area. These services include outreach efforts to special populations including minority groups and elders living in rural America, or expanding services throughout the entire state where services have only been available in designated counties. Title VII-Part C funds have permitted some states to provide low vision assessment and rehabilitation services to older persons.

Seven states have prioritized outreach and rehabilitation services to elderly Americans Indians. The focus of each of these state's efforts related to American Indians is presented below.

Arizona is focusing on developing more culturally appropriate outreach workers for the Hopi, Navajo and Tohono O'Odem Nations. Arizona is providing independent living services to the Navajo reservation in cooperation with the Navajo Vocational Rehabilitation Program. Work on the Hopi Reservation, in cooperation with the Hopi Health Service, has been enhanced by a project being conducted by AFB's Social Research Department in assessing and addressing the needs of visually impaired Hopi. This project is funded by the National Institute of Disability Research and Rehabilitation.

North Carolina's model of mini-centers, a mobil rehabilitation service model which can be taken anywhere in the state, has been taken to the Cherokee reservation.

In Idaho, rehabilitation service providers have been in contact with the Fort Hall Indian Reservation and have conducted staff training workshops for the North Idaho Indian Health Center in Kamiah.

Montana is providing outreach to the seven tribes in its state. Montana operates a federally funded Senior Companion Program which links seniors with visually impaired seniors; 38 percent of their senior companions are volunteering on the seven reservations in the state.

South Dakota has recognized the need for the development of outreach strategies to get American Indians involved in rehabilitation services for the visually impaired, such as the Rosebud Reservation. South Dakota provides culturally relevant rehabilitation teaching services on Indian reservations.

Minnesota is working toward developing effective outreach strategies to introduce rehabilitation services to elderly American Indians.

Wisconsin is conducting vision screenings on reservations.

Texas is also prioritizing the needs of elderly American Indians through other funds. The Dallas Lighthouse has been developing outreach strategies to reach American Indians. However, it is difficult to attract American Indians to services in Texas because of the transient nature of the Indian population in

that state. Most have migrated from Oklahoma and are not reservation-based. Because of the difficulties with the employment market in Texas, many Indian families go back to Oklahoma after a short time.

These are not necessarily the only states working with American Indian elders but are the states which have identified this population as a service priority. Agencies for the blind in other states are more than likely attempting to provide services when they are able to identify those in need. Additional states also provide rehabilitation services to younger American Indians.

Since CHRs have been trained through the project from each of these states, they have the potential to serve as the link between the visually impaired elderly client and the agency for the blind. This can be particularly helpful if an elder wishes training or services beyond that which CHRs are able to provide. Project staff will be in contact with these agencies for the blind in these states to ensure continued outreach efforts and ties.

These outreach efforts targeted to elderly visually impaired American Indians in these eight states represent a major advancement in the field of blindness in outreach to minority populations.

PROJECT SUMMARY

The American Foundation for the Blind is fortunate to have conducted A Training Model to Teach Community Outreach Workers to

Train Elderly Blind and Visually Impaired American Indians Independent Living Skills: Focus on Family Rehabilitation, made possible by funds from the Department of Health and Human Services, Administration on Aging. At the completion of the project the following accomplishments have been made:

- A seven module model curriculum on aging and vision loss issues and independent living skills training has been developed for use by IHS in conducting future CHR week-long training sessions
- The Four Hour Curriculum on Aging and Vision Loss has been developed for inclusion in the Three-Week Basic Training of the CHR program
- Seven specialty training sessions have been conducted
- 250 community health representatives (CHRs) have been trained through the specialty trainings on Aging and Vision Loss
- A "Train the Trainers" session was conducted to teach professional trainers affiliated with the IHS to teach the AFB specialty training
- Seven new trainers are qualified to teach the aging and vision loss curriculum to CHRs
    - 5 trainers completed the training program's practicum and are qualified to teach the week-long specialty training
    - 2 trainers are qualified to teach the four hour component (have not completed the one

.. 2 trainers are qualified to teach the four hour component (have not completed the one week practicum)

. The training curricula developed by AFB have been transferred to the IHS, which will continue to train additional CHRs.

The results of this training project, as well as the seven module model curriculum, will be disseminated to national, regional and local organizations within the field of aging and blindness in addition to the IHS and American Indian organizations. Through these dissemination activities professionals in the field of aging and blindness will become more aware of the pervasiveness of vision loss among American Indian elders, and of their need to provide outreach and services to this growing population.

Recommendations to the Administration on Aging

At the completion of the project the following recommendations are made to the Administration on Aging:

1) AoA staff will continue to advocate to ensure that IHS conducts activities agreed to at the time Phase II was approved by the AoA:

   a) IHS ensure that the Community Health Representative Program incorporate the week-long Aging and Vision Loss course into its "specialty trainings" for CHRs, and conduct four aging and vision loss

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specialty trainings during the first year after the completion of the AoA funded project (four sessions of 40 CHRs each session).

b) The four hour curriculum component of the Aging and Vision course be incorporated into the compulsory three-week basic training program for all new CHRs.

2) IHS will have the course accredited in keeping with other courses conducted by the IHS CHR Program. Accreditation is made through the American Council on Education, Washington, D.C.

3) The Acting Assistant Commissioner of the Office for American Indian Programs at the AoA will advocate for the recommendations posed above with the Director of IHS.

Recommendations to the Indian Health Service

The Community Health Representative Information System (CHRIS)

Each CHR completes an assessment of an individual client to determine the client's problems and service needs. This information is fed into the Community Health Representative Information System (CHRIS). The assessment form currently has no question relating to vision or difficulty seeing. Therefore, CHRIS has no data on the number of elderly American Indians experiencing vision loss problems or the kinds of vision problems. IHS is

urged to revise the assessment instrument to include questions related to vision problems.

Additional Training on Aging and Vision Loss Issues

1. While IHS has agreed to conduct four specialty trainings on Aging and Vision Loss during their fiscal year following the completion of the AoA funded project, IHS should continue to offer this specialty training beyond that first year as long as there is demand for the training among CHRs and their area coordinators and as long as there is significant turnover in staff in the CHR Program.
2. In addition to including four hours of training on Aging and Vision Loss in the three-week basic training, the curriculum should be distributed to instructors of other specialty trainings for brief inclusion of materials where appropriate. The specialty training on diabetes is a good example.

Other Indian Health Service Personnel Who Would Benefit by the Training

IHS Optometric Technicians

During the training session held in Albuquerque in February 1988, project staff met with the Director of Optometric Services for IHS who was interested in the content of AFB's training and its application to optometric technicians to sensitize staff

working in the optometric service about the issues of aging and vision loss. Should IHS monies be available, this service group would benefit from the training. The four hour component would be appropriate. Three CHRs who worked as optometric technicians participated in the AFB training.

Title VI Directors

Another group of service providers who would benefit from the training of the seven module curriculum is the staff who work at the Native American Area Agencies on Aging funded by Title VI of the Older Americans Act.

This population has been suggested as a group to target should additional funds be available. Suggestions have come from CHRs, new trainers and members of the National Advisory Committee to the project. Training these service providers would be a means of reaching the healthy mobile elderly American Indians who go to the reservation or community nutrition sites for lunch and programs. Should funds ever become available for further trainings, this group should be prioritized.

The materials developed and the training conducted have been effective in heightening the level of awareness among IHS personnel about the services available to blind and visually impaired persons and about the types of low-tech assistive devices and adaptive techniques to be learned to enhance the independent and

interdependent functioning among older American Indians experiencing vision loss.

While it is difficult to measure the effectiveness of the training on each individual CHR participant, a statistically significant percentage of survey respondents have been successful in identifying elders with vision problems, introducing elders and their family members to new techniques to carry out activities of daily living, and identifying agencies for the blind in their regions for further rehabilitation services.

Through the application of new knowledge and skills, CHRs have the potential to improve the quality of life for older visually impaired American Indians and their family members and to prevent premature and unnecessary institutionalization and the potential physical, psychological and social isolation of elders experiencing vision loss.

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APPENDICES

NEWS AMERICAN FOUNDATION FOR THE BLIND

15 WEST 16 ST. · NEW YORK, NY 10011

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FOR IMMEDIATE RELEASE

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AFB LAUNCHES PROGRAM TO ASSIST ELDERLY BLIND AND VISUALLY IMPAIRED AMERICAN INDIANS

NEW YORK -- The American Foundation for the Blind (AFB) has launched a 17-month project to help improve the quality of life for elderly blind and visually impaired American Indians.

The project is entitled "A Training Model to Teach Community Outreach Workers to Train Elderly Blind and Visually Impaired American Indians Independent Living Skills: Focus on Family Rehabilitation." It is being funded by a $200,000 grant from the U.S. Administration on Aging.

"The purpose of the program is to ensure physical and psychological independent functioning and to prevent costly and premature institutionalization," said project director Alberta Orr, AFB's national consultant on aging.

Orr said a rehabilitation training model will be developed for 200 Indian community health representatives who will, in turn, teach 10,000 elderly blind and visually impaired American Indians adaptive independent living techniques. Training is scheduled at five sites around the country, and project coordinators will refine and improve the model based on experiences at these sessions. The model will then be disseminated to local, state, and federal

organizations and agencies on aging and blindness as well as to national American Indian organizations.

The first training session was held in Tulsa, OK, in December 1987 and generated a great deal of enthusiasm, according to Jamie Casabianca Hilton, also a national consultant on aging at AFB and director of training for the project. Hilton said the second session is scheduled in Albuquerque, NM, in February and additional sessions are slated in Bismarck, ND, Phoenix, AZ, and San Jose, CA.

The American Foundation for the Blind is a national nonprofit organization that advocates, develops and provides programs and services to help blind and visually impaired people achieve independence with dignity in all sectors of society.

#

A MODEL CURRICULUM TO TEACH COMMUNITY OUTREACH WORKERS TO TRAIN ELDERLY BLIND AND VISUALLY IMPAIRED AMERICAN INDIANS INDEPENDENT LIVING SKILLS: FOCUS ON FAMILY REHABILITATION

AMERICAN FOUNDATION FOR THE BLIND
National Services in Aging
15 West 16th Street
New York, New York 10011

Module 1 - Day 1 (p.m.)

1. Introductions
   - 1.1 Overview of the AFB training project
   - 1.2 Staff introductions
   - 1.3 CHR introductions
   - 1.4 Introduction to rehabilitation
   - 1.5 Film: What Do You Do When You See a Blind Person?
   - 1.6 CHR Information Forms
   - 1.7 Pre-Training Test

Module 2 - Day 2 (a.m.)

2. Understanding Blindness and Low Vision
   - 2.1 "Normal" changes in vision with age
   - 2.2 Definitions
     - 2.2.1 Visual impairment
     - 2.2.2 Low vision
     - 2.2.3 Legal blindness
     - 2.2.4 Functional blindness
   - 2.3 Leading causes of visual impairment and blindness among elderly persons
     - 2.3.1 Cataracts
     - 2.3.2 Glaucoma
     - 2.3.3 Macular degeneration
     - 2.3.4 Diabetic retinopathy
   - 2.4 Functional implications of diseases of the eye
   - 2.5 Film: Not Without Sight
   - 2.6 Low vision services
   - 2.7 Environmental modifications

Module 3 - Day 2 (p.m.)

3. Walking in a Familiar Environment (Sighted Guide and Other Safety Techniques)
   - 3.1 Brief background
   - 3.2 Definitions
     - 3.2.1 Orientation
     - 3.2.2 Mobility
   - 3.3 Travel aids
     - 3.3.1 Human guide
     - 3.3.2 Dog guide
     - 3.3.3 Cane

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3.3.4 Electronic equipment
3.4 Walking with a human guide
3.4.1 Position
3.4.2 Negotiating narrow spaces
3.4.3 Negotiating stairs
3.4.4 Seating
3.4.5 Entering/leaving a car
3.5 Walking without a guide
3.5.1 Trailing
3.5.2 Protective techniques
3.5.3 Sound localization
3.6 Room familiarization

Module 4 - Day 2 (p.m.)

4. Psychosocial Aspects of Aging and Vision Loss
Discussion by CHRs concerning:
4.1 Losses
4.2 Reactions
4.3 Attitudes
4.4 The family and rehabilitation
4.5 Film: Aging and Vision: Declarations of Independence
4.6 The elderly visually impaired person as a learner
4.7 Principles of instruction

Module 5 - Day 3 (a.m. and p.m. and Day 4 a.m.)

5. Daily Living Skills
5.1 Communication skills
5.1.1 Telephone dialing
5.1.1.1 Rotary
5.1.1.2 Push-button
5.1.2 Telling time
5.1.2.1 Clocks and watches
5.1.2.2 Adapted alarm clock
5.1.2.3 Braille watch
5.1.3 Signature guide
5.1.4 Large print
5.1.5 Use of cassette recorder
5.2 Personal grooming
5.2.1 Brushing teeth
5.2.2 Shaving
5.2.3 Applying lipstick
5.3 Eating skills
5.3.1 Place setting/food location
5.3.2 Cutting food with knife and fork
5.3.3 Using salt and pepper
5.3.4 Spreading

Day 3 - (p.m.)

5.4 Clothing care
5.4.1 Clothing identification
5.4.2 Clothing organization
5.4.3 Adaptive sewing items
5.5 Communication
5.5.1 Braille
5.5.2 Money identification
5.5.2.1 Coins
5.5.2.2 Bills
5.5.3 Large print
5.6 Film: Blindness: A Family Matter

Day 4 - (a.m).

5.7 Household management
5.7.1 Cleaning a surface
5.7.2 Identifying personal and household items
5.7.3 Organization
5.8 Kitchen Safety
5.8.1 Pouring liquids
5.8.2 Use of knives
5.8.3 Centering pots and pans on stove
5.9 Handouts
5.9.1 Rotary and push-button dials
5.9.2 Braille alphabet and numbers card
5.9.3 Sewing kit
5.9.4 Hi Marks
5.9.5 Signature card
5.9.6 Double spatula

Module 6 - Day 4 (p.m.)

6. Adapted Recreation and Leisure Activities
6.1 Recreation activities
6.1.1 Individual
6.1.2 Group
6.2 Adapted games
6.3 Group discussion of cultural activities

Module 7 - Day 4 (p.m.)

7. Knowledge of Resources and Advocacy Skills
7.1 Federal resources
7.2 State resources
7.3 Local resources
7.4 How to gain access to resources
7.5 Advocacy

8. Written Curriculum Review

Day 5 - (a.m.)

9. Wrap-up of 7 Module Curriculum
9.1 Questions and Answers
9.2 Use of training on the job
9.3 How learning will be shared with co-workers
9.4 Post-Training Test
9.5 Training Program Evaluations
9.6 Distribution of Certificates

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

TO BE COMPLETED BY CHR PARTICIPANTS

CHR INFORMATION FORM

Name _____
Job Title _____

1. How many people are in your case load? _____

2. How many of the elderly (over 60) in your case load: have poor eyesight _____ or are blind?_____

3. In what settings do you see them?

PLEASE CHECK:

Home _____
Senior Center _____
Nutrition Site _____
Clinic _____
Transportation _____
Other (fill in) _____

4. Have you had any previous training in visual impairment and blindness? Yes____ No____

If so, who provided the training?_____

5. a) What do you think are the main problems of elderly clients who are losing their vision or are blind?

PLEASE LIST:

6. What resources exist in your area for clients who are visually impaired or blind?

_____

_____

_____

_____

7. What experience have you had with persons who have trouble seeing or are blind?

_____

_____

_____

8. What do you hope to learn during this training session?

_____

_____

_____

American Indian Rehabilitation Project
Training Native American Trainees
in
Aging and Vision Loss

Pre-Training Test

Name _____ Date _____
Position _____

Directions - Please circle the answer which most clearly represents what you believe to be most accurate for each statement.

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
1) Most legally blind people have some sight.	1	2	3	4
2) Blind people have more acute hearing and sense of touch than sighted people.	1	2	3	4
3) A blind person should not have to meet the same standards as others.	1	2	3	4
4) If I were suddenly blinded, I might wonder if life were worth living.	1	2	3	4
5) Blind people are constantly worried about the future.	1	2	3	4
6) Visually handicapped people see more than they will admit.	1	2	3	4
7) Blindness has little or no effect upon intelligence.	1	2	3	4
8) Blind people yearn for sight more than anything else.	1	2	3	4
9) A blind person is not afraid to express his feelings.	1	2	3	4
10) Blind people need help in carrying out routine activities of living.	1	2	3	4
11) A blind person can never really be happy.	1	2	3	4

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
12) When speaking to a blind person one should first address him by name or touch his arm.	1	2	3	4
13) A blind person can't afford to talk back to people.	1	2	3	4
14) Blind people can be taught to do most of the things they were doing prior to blindness.	1	2	3	4
15) Some sighted people feel a little guilty because they can see and others cannot.	1	2	3	4
16) A blind person standing on a street corner is waiting for someone to take his arm and help him across the street.	1	2	3	4
17) It is possible to know the beauty of the world without sight.	1	2	3	4
18) I might feel uneasy in a social situation with a blind person.	1	2	3	4
19) My attitude toward a blind person would be based more upon his personality than upon the fact that he is blind.	1	2	3	4
20) It is okay to use words such as "look" and "see" when speaking to a blind person.	1	2	3	4
21) It is bitterly degrading for a disabled person to depend so much upon others.	1	2	3	4
22) I might feel uncertain how to act with a blind co-worker.	1	2	3	4
23) Blind people are more easily upset than sighted people.	1	2	3	4

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
24) Blind people are naturally more inward-looking than sighted people.	1	2	3	4
25) Most blind people think and act alike.	1	2	3	4
26) Where I work, or used to work, there is no job above a menial capacity which a blind person could fill.	1	2	3	4
27) There are worse things than being blind.	1	2	3	4
28) Blind people should be given a pension to live on without working.	1	2	3	4
29) Acceptance of blindness is the same thing as acceptance of anything else in life.	1	2	3	4
30) I would feel comfortable working with a blind co-worker.	1	2	3	4
31) The blind adult is not quite as mature or "grown-up" as the sighted adult.	1	2	3	4
32) If a rehabilitation counselor were consulted, there might be a job for a blind person where I work, or used to work.	1	2	3	4
33) Blind people have as many interests as sighted people.	1	2	3	4

34) Imagine that you have received an accidental disability. Mark a different number after each one, putting a 1 after the most severe to you, and continue 2,3,4,5 in order of decreasing severity to you.

Amputation of an arm _____
Deafness _____
Blindness _____
Amputation of a leg _____
Facial burns _____

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT

CLIENT ASSESSMENT FORM

(To be completed at initial interview of client)

Client: Name _____
Address: _____
_____
Phone#: _____

Dates of Service: _____
Degree of Vision Loss: _____
Physical Limitations: _____

Independent Living Skills	Can Perform Independently	Can Perform/w Assistance	Cannot Perform but Would Like to Learn	Cannot Perform B Not Ready For Rehab
I. HOME MANAGEMENT:				
1. Housecleaning	_____	_____	_____	_____
Identifying Household and Personal Items	_____	_____	_____	_____
2. Home Safety	_____	_____	_____	_____
3. Orientation	_____	_____	_____	_____
4. Labeling:				
a) Household Items	_____	_____	_____	_____
b) Clothing	_____	_____	_____	_____
5. Cooking:				
a) Stove	_____	_____	_____	_____
b) Oven	_____	_____	_____	_____
c) Center Pan over Flame	_____	_____	_____	_____
6. Kitchen Safety	_____	_____	_____	_____
a) Pouring Cold Liquids	_____	_____	_____	_____
b) Using Knives	_____	_____	_____	_____
II. DAILY LIVING:				
1. Money Identification:				
a) Paper	_____	_____	_____	_____
b) Coin	_____	_____	_____	_____

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dependent Living Skills	Can Perform Independently	Can Perform/w Assistance	Cannot Perform But Would Like to Learn	Cannot Perform Bu Not Ready For Rehab
. DAILY LIVING (CONT'D):				
2. Clothing Management:				
a) Selection of Appropriate Clothing	_____	_____	_____	_____
b) Laundering and Care	_____	_____	_____	_____
(Describe Method Used)	_____			
3. Eating:				
a) Cutting Food	_____	_____	_____	_____
b) Identifying Food	_____	_____	_____	_____
4. Personal Care:				
a) Applying Lipstick	_____	_____	_____	_____
b) Shaving	_____	_____	_____	_____
c) Applying Tooth-paste to Tooth-brush	_____	_____	_____	_____
I. COMMUNICATION:				
1. Writing:				
a) Signature	_____	_____	_____	_____
2. Phone Dialing:				
a) Rotary	_____	_____	_____	_____
b) Pushbutton	_____	_____	_____	_____
3. Telling Time	_____	_____	_____	_____
(Describe Method Used)	_____			
. MOBILITY:				
1. Indoor	_____	_____	_____	_____
2. Outdoor	_____	_____	_____	_____
MISCELLANEOUS:				
1. Sewing:				
a) Hand	_____	_____	_____	_____
b) Machine	_____	_____	_____	_____
2. Medications:				
a) Identification	_____	_____	_____	_____
b) Organization	_____	_____	_____	_____

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Independent Living Skills	Can Perform Independently	Can Perform/w Assistance	Cannot Perform But Would Like to Learn	Cannot Perform Not Reac For Rehe
V. MISCELLANEOUS (CONT'D):				
3. Personal Interests:				
a) Hobbies	_____	_____	_____	_____
b) Games	_____	_____	_____	_____
c) Other	_____	_____	_____	_____

VI. COMMENTS: _____

_____

_____

THIS PROJECT WAS MADE POSSIBLE BY A GRANT FROM THE ADMINISTRATION ON AGING.
12/87

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A Training Model to Teach Community Outreach Workers to Train Elderly Blind and Visually Impaired American Indians Independent Living Skills: Focus on Family Rehabilitation

KEY WORDS FOR THE SEVEN MODULE CURRICULUM

1. AER or AERBVI - Association for Education and Rehabilitation of the Blind and Visually Impaired. The professional membership organization of the field of blindness for the United States and Canada. Holds international regional and state conferences; conducts legislative activity.

2. AFB - the American Foundation for the Blind is a national, nonprofit organization founded in 1921 to help improve the standards of service for blind and visually impaired people. AFB provides direct assistance and referral services in partnership with over 1,000 specialized agencies as well as public schools, universities, senior centers and businesses. AFB is headquartered in New York City, with regional offices in Atlanta, Chicago, Dallas, San Francisco, New York and Washington, D.C. AFB provides the following services:

   a) Offers schools, agencies and organizations the professional services of national and regional consultants on employment, aging, rehabilitation, orientation and mobility, education, low vision, early childhood and multiple disabilities.

   b) Provides public education about blindness.

   c) Publishes books, pamphlets and periodicals, including the Journal of Visual Impairment and Blindness, the leading professional journal in the field, and AFB NEWS, a quarterly newsletter for general readership.

   d) Houses the National Technology Center whose engineers conduct high technology research development.

   e) Houses the M. C. Migel Memorial Library and Information Center, one of the largest collections of print materials on blindness in the world and the largest circulating library on blindness in the United States.

   f) Records and manufactures over 500 Talking Book titles each year under contract to The Library of Congress.

   g) Conducts technological, education and social research on visual impairment and blindness.

   h) Maintains a governmental relations office in Washington, D. C. to consult on legislative issues and

represent AFB before Congress and governmental agencies.

i) Adapts, evaluates, manufactures and sells special aids and products to help blind and visually impaired people.

j) Conducts local, regional and national conferences.

3. Activities of Daily Living - All the things people do every day such as bathing, dressing, cooking, eating, cleaning, washing clothes, shopping, recreation.

4. Adaptive Devices - Devices which enable a blind or visually impaired individual to continue to perform everyday tasks with limited or no vision, i.e. a signature guide, talking clock, script writing guide.

5. Braille - A system of raised dots which enables a blind person to read by touch.

6. Cataract - A cloudiness or opacity in the lens of the eye which results in poor, or no, vision.

7. Clue - An object, sound or smell that provides information for orientation but is not permanent like a landmark.

8. Contrast - Distinct differences between objects or objects and background or areas in environment, with respect to light or color.

9. Diabetic Retinopathy - Blurred vision or blocked vision caused by a disorder of blood vessels in the retina.

10. Direction Taking - The method by which a blind or visually impaired person uses verbal directions given by another person to become oriented and more through an unfamiliar environment.

11. Dog Guide - A specially trained dog to help guide a blind person with instructions from the blind person.

12. Floaters - Small particles consisting of cells or libris which move in the vitreous.

13. Field of Vision - The entire area which can be seen without shifting the gaze or head. (Total field of vision is 180 degrees.)

14. Glaucoma - Loss of vision caused by too much fluid pressure in the eye.

15. Landmark - An object, sound or smell that is always in the same place (a tree, a striking clock, a bakery).

16. Legal Blindness - Visual acuity of 20/200 or less in the better eye, with correction, or visual acuity of more than 20/200 if the field of vision is 20 degrees or less.

17. Light Perception - Ability to distinguish light from dark.

18. Long Cane - A specially constructed cane which a blind person uses as an extension of the sense of touch, to move about independently.

19. Low Vision - A vision loss that causes problems in carrying out activities of daily living but which still allows some visual ability.

20. Low Vision Aids - Special lenses or electronic devices that are more powerful than regular eyeglasses.

21. Macular Degeneration - Gradual loss of fine reading vision, caused by damage to the macula (part of the retina).

22. Mobility - The ability to find the way from one's present position to another desired place in the environment.

23. Ophthalmologist - A Doctor of Medicine (M.D.) or Doctor of Osteopathy (D.O.) who treats diseases of the eye, performs eye surgery and prescribes corrective lenses and medicines for the eye.

24. Optometrist - A Doctor of Optometry (O.D.) who tests the eyes for defects in vision for the purpose of prescribing corrective lenses.

25. Optician - A person who makes corrective lenses as prescribed by an ophthalmologist or optometrist but who does not examine eyes.

26. Optic Nerve - The special nerve of the sense of sight which carries messages from the retina to the brain. (If the optic nerve is damaged vision is lost and the condition is irreversible.)

27. Optic Atrophy - Degeneration of the optic nerve tissue which carries messages from the retina to the brain about what is seen.

28. Orientation - The use of all senses to determine one's position and relationship to significant objects in the environment (the ability to know where one is in the environment).

29. Rehabilitation - The process of helping an individual who has an impairment to make the best use of his/her physical and environmental resources so as to live life as fully as he or she wishes.

30. Rehabilitation Center - A facility which offers rehabilitation services to blind and visually impaired persons including rehabilitation teaching, orientation and mobility, low vision rehabilitation and services, recreation, social work, vocational counseling, etc.

31. Retina - Tissue in the back of the eye which transmits messages to the brain.

32. Room Familiarization - The systematic method by which a blind or visually impaired person becomes familiar with an uncommon physical environment, i.e. a room, its parameter and its contents, in order to move about to locate objects.

33. Sighted (or human) Guide - An individual who guides a blind person, with the blind person grasping his/her arm lightly above the elbow, walking a half step behind the guide.

34. Signature Guide - An adaptive device consisting of a 2 x 3 inch rectangular piece of cardboard or plastic with a narrow opening in the center the size of an average signature; used by a blind or visually impaired person to sign his/her name within the given space. (If signature must be on a line, such as on a form, it may be used with the assistance of a sighted person who places the guide on the line.)

35. Sound Location - A sensory development skill used by a blind or visually impaired person to assess the physical environment.

36. Squaring Off - A term used in orientation and mobility training; to align oneself perpendicular to a wall so that when walking from the wall one can walk at a 90 degree angle.

37. Trailing - The use of the back of the fingers to follow lightly over a straight surface (wall, table, etc.) to locate objects, to move about and to help know where one is.

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

NAME _____

WRITTEN CURRICULUM REVIEW

1. What is rehabilitation? _____

_____

2. List 2 reasons why it is important to involve family members in rehabilitation of the older visually impaired person.

_____

_____

3. What is legal blindness? _____

_____

_____

4. List 2 of the leading causes of blindness among the elderly.

_____

_____

_____

5. List 2 types of low vision aids. _____

_____

_____

_____

6. List 3 possible reactions to vision loss among the elderly.

_____

_____

_____

_____

7. List 3 ways to use color contrast to help a low vision client in the home.

8. Name 2 aids a blind person may use to get around.

9. Describe the technique of sighted guide.

10. List 3 ways a totally blind person takes in information from the environment.

11. List 3 things to keep in mind as you are teaching an older person.

12. Describe one way in which you would teach a client to use the telephone.

13. How would you instruct a blind person to organize money ($1.00, $5.00 and $10.00 bills)?

14. Describe 1 technique for putting toothpaste on a toothbrush.

15. List 3 ways of identifying clothing.

16. Describe how you would help a blind person know what is on his/her plate.

17. How would you teach a client to clean a flat surface?

18. How would you teach a client to pour cold liquids?

19. Name 4 games which are adapted for the visually impaired.

20. List 3 types of agencies which may be helpful in serving a blind client.

21. List 2 points which are important in advocating on behalf of clients.

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

TRAINING PROGRAM EVALUATION

1. Please rate the following parts of the curriculum presented below.

	Very Useful	Useful	Somewhat Useful	Not Useful
a. Introduction to Rehabilitation	_____	_____	_____	_____
b. Family Involvement in Rehabilitation	_____	_____	_____	_____
c. Understanding Blindness and Low Vision:				
Definition of Visual Impairment				
Causes of Vision Loss Among the Elderly	_____	_____	_____	_____
Low Vision Services and Aids	_____	_____	_____	_____
Environmental Modifications	_____	_____	_____	_____
d. Psychosocial Aspects of Aging and Vision Loss	_____	_____	_____	_____
e. Walking in Familiar Environment:	_____	_____	_____	_____
Travel Aids	_____	_____	_____	_____
Walking with a Human Guide	_____	_____	_____	_____
Walking without a Guide	_____	_____	_____	_____
Room Familiarization	_____	_____	_____	_____
f. Daily Living Skills:				
Communication Skills				
Telephone Dialing	_____	_____	_____	_____
Telling Time	_____	_____	_____	_____
Signature Guide	_____	_____	_____	_____
Money Identification	_____	_____	_____	_____
Personal Grooming				
Shaving	_____	_____	_____	_____
Applying Toothpaste to Toothbrush	_____	_____	_____	_____
Applying Lipstick	_____	_____	_____	_____
Clothing Care				
Clothing Identification	_____	_____	_____	_____
Clothing Organization	_____	_____	_____	_____
Hand Washing	_____	_____	_____	_____
Adaptive Sewing Items	_____	_____	_____	_____

f. Daily Living Skills (Cont'd):	Very Useful	Useful	Somewhat Useful	Not Useful
Eating Skills				
Place Setting	_____	_____	_____	_____
Cutting Food	_____	_____	_____	_____
Using Salt and Pepper	_____	_____	_____	_____
Spreading	_____	_____	_____	_____
Household Management				
Cleaning	_____	_____	_____	_____
Identifying Household and Personal Items	_____	_____	_____	_____
Organization	_____	_____	_____	_____
Kitchen Safety				
Pouring Liquids	_____	_____	_____	_____
Use of Knives	_____	_____	_____	_____
Centering Pots and Pans	_____	_____	_____	_____
g. Adapted Recreation and Leisure:				
Recreational Activities	_____	_____	_____	_____
Adapted Games	_____	_____	_____	_____
h. Knowledge of Resources	_____	_____	_____	_____
i. Advocacy Skills	_____	_____	_____	_____

2. How would you evaluate each of the teaching methods used during training week?

a.	Lecture	_____	_____	_____	_____
b.	Role Playing	_____	_____	_____	_____
c.	Discussion	_____	_____	_____	_____
d.	"Hands On" Activities	_____	_____	_____	_____
e.	Simulation Exercises	_____	_____	_____	_____
f.	Films	_____	_____	_____	_____

. List 3 ways in which this week-long learning has effected you personally and professionally. Please describe.

1.

2.

3.

lease share any additional comments.

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MAJOR PROBLEMS CONFRONTING ELDERLY VISUALLY IMPAIRED NATIVE AMERICAN AS IDENTIFIED BY COMMUNITY HEALTH REPRESENTATIVES

Concrete Problems Facing Native American Elders

- no transportation is available to get to needed services
- it is difficult to cook and clean
- it is difficult to select clothing and care for it
- it is not possible to identify medication
- it is difficult to get bills paid
- it is no longer possible to enjoy crafts or other leisure activities
- there are no opportunities for early diagnosis of eye condition for many Native Americans
- no help is available to carry out tasks
- there is little community support

Psychological Problems in Accepting Vision Problems

- Native American elders think their eyes will get better
- elders feel their vision loss is the result of ill deeds or the breaking of a traditional taboo
- many elders only seek the medical advice of the medicine man or shamen for cultural remedies
- they fear surgery and refuse medical assistance
- even when medical help is available, elders do not follow doctor's advice
- elders cannot learn to deal with what they can no longer do
- they are fearful of staying alone
- they are frightened to go to an unfamiliar environment
- they feel inadequate, no longer needed
- they do not want to be a burden to their families so they do not ask for the help they need
- they want to be independent and feel they will never be again.

PRIMARY AREAS OF LEARNING IDENTIFIED BY COMMUNITY HEALTH REPRESENTATIVES AT THE END OF THE FIVE DAY TRAINING SESSIONS

1. The training changing my attitude toward blind people.
2. The training gave me better insight about blindness; "It opened my eyes" to what a blind person goes through.
3. I learned how to approach family members of elderly blind clients, to make family members more aware of their relative's needs and abilities.
4. I learned that blind people can be useful and independent and that they can be involved in community life.
5. I learned that a small change, such as learning a new small skill can make a big difference in the life of a blind person.

PRIMARY AREAS OF LEARNING TO BE IMPLEMENTED BY CHRs UPON RETURN TO THE RESERVATION OR NATIVE AMERICAN COMMUNITY

1. I will be able to guide patients into and around the health clinic and in and out of the transporting van.
2. I will instruct elders how to make the best use of lighting and color contrast.
3. I will be able to teach the granddaughter of a blind client how to help her grandmother up an down the steps by using sighted guide.
4. I will encourage members of my tribe to have regular vision checkups.
5. I will involve the client in the planning of their care as a result of this training.
6. I will try to start a support group for blind and low vision clients.
7. I will include more information on preventing blindness and eye diseases associated with aging during health promotion activities on my reservation.
8. As a health educator, I will try to teach members of my tribe, particularly young children, so that attitudes about the blind and blindness will change at an early stage.

American Indian Rehabilitation Project
Training Native American Trainees
in
Aging & Vision Loss

Post-Training Test

Name _____ Date _____
Position _____

Directions - Please circle the answer which most clearly represents what you believe to be most accurate for each statement.

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
1) Most legally blind people have some sight.	1	2	3	4
2) Blind people have more acute hearing and sense of touch than sighted people.	1	2	3	4
3) A blind person should not have to meet the same standards as others.	1	2	3	4
4) If I were suddenly blinded, I might wonder if life were worth living.	1	2	3	4
5) Blind people are constantly worried about the future.	1	2	3	4
6) Visually handicapped people see more than they will admit.	1	2	3	4
7) Blindness has little or no effect upon intelligence.	1	2	3	4
8) Blind people yearn for sight more than anything else.	1	2	3	4
9) A blind person is not afraid to express his feelings.	1	2	3	4
10) Blind people need help in carrying out routine activities of living.	1	2	3	4
11) A blind person can never really be happy.	1	2	3	4

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
12) When speaking to a blind person, one should first address him by name or touch his arm.	1	2	3	4
13) A blind person can't afford to talk back to people.	1	2	3	4
14) Blind people can be taught to do most of the things they were doing prior to blindness.	1	2	3	4
15) Some sighted people feel a little guilty because they can see and others cannot.	1	2	3	4
16) A blind person standing on a street corner is waiting for someone to take his arm and help him across the street.	1	2	3	4
17) It is possible to know the beauty of the world without sight.	1	2	3	4
18) I might feel uneasy in a social situation with a blind person.	1	2	3	4
19) My attitude toward a blind person would be based more upon his personality than upon the fact that he is blind.	1	2	3	4
20) It is okay to use words such as "look" and "see" when speaking to a blind person.	1	2	3	4
21) It is bitterly degrading for a disabled person to depend so much upon others.	1	2	3	4
22) I might feel uncertain how to act with a blind co-worker.	1	2	3	4
23) Blind people are more easily upset than sighted.	1	2	3	4

Statements about Blindness and Blind Persons	Strongly Agree	Agree	Disagree	Strongly Disagree
24) Blind people are naturally more inward-looking than sighted people.	1	2	3	4
25) Most blind people think and act alike.	1	2	3	4
26) Where I work, or used to work, there is no job above a menial capacity which a blind person could fill.	1	2	3	4
27) There are worse things than being blind.	1	2	3	4
28) Blind people should be given a pension to live on without working.	1	2	3	4
29) Acceptance of blindness is the same thing as acceptance of anything else in life.	1	2	3	4
30) I would feel comfortable working with a blind co-worker.	1	2	3	4
31) The blind adult is not quite as mature or "grown-up" as the sighted adult.	1	2	3	4
32) If a rehabilitation counselor were consulted, there might be job for a blind person where I work, or used to work.	1	2	3	4
33) Blind people have as many interests as sighted people.	1	2	3	4

34) Imagine that you have received an accidental disability. Mark a different number after each one, putting a 1 after the most severe to you, and continue 2,3,4,5 in order of decreasing severity to you.

Amputation of an arm _____
Deafness _____
Blindness _____
Amputation of a leg _____
Facial burns _____

AMERICAN FOUNDATION FOR THE BLIND

CHR Training Program

This document certifies that

184

has successfully completed
the one week training course for CHRs
in "Aging and Vision Loss"
including adaptive techniques in independent living.

Alberta L. Orr	Ruth Kaarlela	Date
Project Director	*Rehabilitation Teacher*	

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Appendix L

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15 WEST 16 STREET
NEW YORK, NEW YORK 10011

CHR Training Program
on Aging and Blindness and
Visual Impairment Among Native Americans

FOLLOW-UP SURVEY

1) Have you identified low vision clients in your caseload which you were not aware of before the training?

Yes ___ No ___

How many visually impaired clients are in your caseload? _____

2) Have you talked with blind or low vision clients about techniques you learned in the training? Yes ___ No ___

How many clients have you told? _____

Which techniques? List:

_____

_____

_____

_____

How many clients have you told? _____

3) Have you been able to refer any clients to any blindness services? Yes ___ No ___

If yes, where? _____

_____

4) Now that several months have passed, which skills that you learned during training have been most useful to you in your work with clients? Please check.

Communication Skills
Telephone dialing ___
Telling time ___

Signature guide ____
Money Identification ____
Personal Grooming
Shaving ____
Applying toothpaste to toothbrush ____
Applying lipstick ____
Clothing Care
Clothing identification ____
Clothing organization ____
Hand Washing ____
Adaptive Sewing Items ____
Eating Skills
Place setting ____
Cutting food ____
Using salt and pepper ____
Spreading ____
Household Management
Cleaning ____
Identifying household and personal items ____
Labeling ____
Kitchen Safety
Pouring liquids ____
Cutting and paring ____

5) Are you using sighted guide when you walk with visually impaired clients? Yes ___ No ___

6) Have you taught sighted guide to your clients so they may use it with others? Yes ___ No ___

7) Have you taught sighted guide to any family members? Yes ___ No ___

8) Have you been able to refer any clients to low vision services? Yes ___ No ___

How many? _____

9) Do you know where low vision services are available near your reservation or in your community? Yes ___ No ___

Where? _____

10) Have you assisted visually impaired and/or blind clients in developing an adapted recreation or leisure activity? Yes ___ No ___

What activity? _____

11) Have you used some of the information discussed during the psychosocial adjustment to vision loss section of the training to understand your client's reaction to vision loss? Yes ___ No ___

12) Has this helped you interpret your client's reactions to vision loss? Yes ___ No ___

13) Have you used any of the items we gave you to help your client? Yes ___ No ___
Please check.

____ Hi Marks
____ Signature guide
____ Playing cards
____ Telephone dial
____ Double spatula

14) If you were able to get assistance from a local agency for the blind, what would you like help with most? List as many areas as you wish:

_____

_____

_____

_____

_____

This project is made possible by a grant from the Department of Health and Human Services, Administration on Aging.

AMERICAN FOUNDATION FOR THE BLIND
15 WEST 16 STREET
NEW YORK, NEW YORK 10011

CHR Training Program
on Aging and Vision Loss
Among Native American Elders

FOLLOW-UP SURVEY

NAME_____

Check the training session you attended:

____ Tulsa, Oklahoma, December 1987
____ Albuquerque, New Mexico, February 1988
____ San Francisco, California, April 1988
____ Albuquerque, New Mexico, June 1988
____ Bismarck, North Dakota, August 1988
____ Oklahoma City, Oklahoma, September 1988
____ Tucson, Arizona, August 1989
____ Portland, Oregon, January 1990

1) Are there visually impaired clients in your caseload whom you were not aware of before the training?
Yes ___ No ___

2) How many visually impaired clients are in your caseload? _____

3) How many clients are there in your total caseload? _____

4) Have you talked with visually impaired clients about techniques you learned in the training? Yes ___ No ___

5) With how many clients have you talked? _____

6) Which techniques did you discuss?

_____

_____

_____

_____

7) How many clients have you taught? _____

8) Have you taught family members? _____

9) Have you been able to refer any clients to any agencies for the blind and visually impaired in your local area or state?

Yes ___ No ___

10) If yes, to what agency?

_____

_____

11) Do you know if there is an agency for the visually impaired near where you work?

_____

12) Which skills that you learned during training have been most useful to you in your work with clients? Please check.

Communication Skills
- Telephone dialing ____
- Telling time ____
- Low vision materials ____
- Using a signature guide ____

Personal Management
- Money Identification ____

Personal Grooming
- Shaving ____
- Applying toothpaste to toothbrush ____
- Applying lipstick ____

Clothing Care
- Clothing identification ____
- Clothing organization ____

Using Adaptive Sewing Items ____

Eating Skills
- Place setting ____
- Cutting food ____
- Using salt and pepper ____
- Spreading ____

Household Management
- Cleaning ____
- Identifying household and personal items ____
- Labeling ____

Kitchen Safety
- Pouring liquids ____
- Cutting and paring ____

Environment for Contrast ____

13) Are you using sighted guide when you walk with visually impaired clients? Yes ___ No ___

14) Have you taught sighted guide to your clients so they may use it with others? Yes ___ No ___

15) Have you taught sighted guide to the client's family members or friend? Yes ___ No ___

16) Do you know where low vision services are available near your reservation or in your community? Yes ___ No ___

If yes, where? _____

17) Have you been able to refer any clients to low vision services? Yes ___ No ___

How many clients? _____

18) Have you assisted visually impaired and/or blind clients in developing an adapted, cultural, traditional, recreational or leisure activities? Yes ___ No ___

If yes, describe the activities._____

_____

19) Has any of the information discussed during the psychosocial adjustment to vision loss section of the training been helpful to you in understanding your
a) client's reactions to vision loss? Yes ___ No ___

b) the client's family reactions? Yes ___ No ___

20) Have you used any of the items we gave you to help your client? Yes ___ No ___

Please check.

____ Hi Marks
____ Signature guide
____ Playing cards
____ Telephone dial
____ Double spatula

21) **Which reading materials have been useful, if any.**

_____

_____

22) **If you needed to get assistance from a local agency for the blind, what would you like help with most? List as many areas as you wish:**

_____

_____

_____

_____

_____

Thank you for your time in completing this follow-up survey.

This project is made possible by a grant from the Department of Health and Human Services, Administration on Aging.

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

Tucson, Arizona
July 31 - August 11, 1989

Qualifying Criteria for Trainer Certification

1) Each trainer will prepare a lesson plan for teaching a skill.

Lesson plan will include:

- content to be covered
- teaching method(s)
- materials required to teach a skill
- learning activity planned
- after-session learning activity assignment
- reading assignment

2) Each trainer will teach a skill area to the professional trainers individually.

3) Each trainer will complete a written qualifying exam.

4) Each trainer will evaluate the training curriculum for cultural relevance and make all necessary modifications, corrections and additions required.

5) Each trainér will teach 2 to 3 components of the curriculum to the class of 30 CHRs, August 7-11, 1989.

6) Each trainer will describe and demonstrate to the class an adaptive technique and its skill instruction. Each will select a skill from a list of 12 skill areas.

7) Each trainer will read an autobiography and be prepared to participate in a discussion regarding the following features of the autobiography:

a) What was the significance of blindness to the individual?
b) How did he/she cope?
c) How did blindness affect relationships with family and significant others?
d) How satisfactorily do you feel the individual learned to live with his/her visual impairment?
e) What were the strengths/positive factors and the limitations/negative factors associated with the individual?

TRAINING THE TRAINERS
AMERICAN INDIAN REHABILITATION PROJECT

SKILL AREAS FOR DESCRIPTION AND DEMONSTRATION BY TRAINERS

1. sighted guide - basic technique
   up and down stairs
   negotiating narrow spaces
   locating a seat and setting

2. walking without a guide
   protective techniques
   trailing
   sound localization

3. room familiarization

4. communication skills
   telephone dialing
   rotary
   push button

5. telling time
   clocks and watches
   use of timers

6. eating skills
   place setting / food location on plate
   cutting food
   using salt & pepper

7. pouring liquids
   spreading

8. signature guide, envelope guide, check guide
   writing on a line

9. presentation on horticulture/gardening for blind persons

10. demonstration of the us of his marks

11. instruction on how to adapt a leisure time activity for a blind or visually impaired person

12. clothing identification, care and organization

13. Cleaning a flat surface

AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
TRAINING THE TRAINERS

Tucson, Arizona
July 31 - August 11, 1989

TRAINING THE TRAINERS WRITTEN QUALIFYING EXAM

Please respond to the following questions on the separate sheets attached. You will want to be as concise but as detailed as possible to demonstrate the depth of your knowledge and understanding of the issues and skills taught in the course. Feel free to use as much space as you require.

1. Define legal blindness and low vision.

2. List the four common causes of visual impairment among the elderly and describe the functional implications of each.

3. Describe the ways in which rehabilitation of elderly persons is unique as compared to traditional medical treatment or general rehabilitation.

4. Describe the situation of a blind or visually impaired person (one who you are familiar with or might encounter in the future). Include the following factors in your description:
   - age
   - living situation
   - family supports
   - symptoms of eye conditions
   - changes in daily activities as a result of eye problem
   - losses that the older person experience
   - family reactions
   - what skill instruction will the older person require
   - what community resources may be needed
   - who might be the link between client and resources

5. Our effort has been to instruct you on the various aspects of the field of blindness and low vision. Would you identify and describe what in this experience made the greatest impact upon your professional understanding.

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AMERICAN FOUNDATION FOR THE BLIND
AMERICAN INDIAN REHABILITATION PROJECT
CHR TRAINING PROGRAM

TRAINING PROGRAM EVALUATION

1. Please critique the total experience from your vantage point as a trainer.

2. Please rate the following parts of the curriculum presented below.

	Very Useful	Useful	Somewhat Useful	Not Usefu
a. Introduction to Rehabilitation	_____	_____	_____	_____
b. Family Involvement in Rehabilitation	_____	_____	_____	_____
c. Understanding Blindness and Low Vision:				
Definition of Visual Impairment				
Causes of Vision Loss Among the Elderly	_____	_____	_____	_____
Low Vision Services and Aids	_____	_____	_____	_____
Environmental Modifications	_____	_____	_____	_____
d. Psychosocial Aspects of Aging and Vision Loss	_____	_____	_____	_____
e. Walking in Familiar Environment:	_____	_____	_____	_____
Travel Aids	_____	_____	_____	_____
Walking with a Human Guide	_____	_____	_____	_____
Walking without a Guide	_____	_____	_____	_____
Room Familiarization	_____	_____	_____	_____
f. Daily Living Skills:				
Communication Skills				
Telephone Dialing	_____	_____	_____	_____
Telling Time	_____	_____	_____	_____
Signature Guide	_____	_____	_____	_____
Money Identification	_____	_____	_____	_____
Personal Grooming				
Shaving	_____	_____	_____	_____
Applying Toothpaste to Toothbrush	_____	_____	_____	_____
Applying Lipstick	_____	_____	_____	_____
Clothing Care				
Clothing Identification	_____	_____	_____	_____
Clothing Organization	_____	_____	_____	_____
Hand Washing	_____	_____	_____	_____
Adaptive Sewing Items	_____	_____	_____	_____

f. Daily Living Skills (Cont'd):	Very Useful	Useful	Somewhat Useful	Not Useful
Eating Skills				
Place Setting	_____	_____	_____	_____
Cutting Food	_____	_____	_____	_____
Using Salt and Pepper	_____	_____	_____	_____

Spreading				
Household Management				
Cleaning				
Identifying Household and Personal Items				
Organization				
Kitchen Safety				
Pouring Liquids				
Use of Knives				
Centering Pots and Pans				

g. Adapted Recreation and Leisure:

Recreational Activities				
Adapted Games				

h. Knowledge of Resources

i. Advocacy Skills

3. How would you evaluate each of the teaching methods used during training week?

a. Lecture				
b. Role Playing				
c. Discussion				
d. "Hands On" Activities				
e. Simulation Exercises				
f. Films				

4. List 3 ways in which this week-long learning has effected you personally and professionally. Please describe.

1.

2.

3.

Please share any additional comments.

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The Four-Hour Component For CHR Basic Training

I. Understanding Blindness & Low Vision

1. Incidence & Prevalence

1.2 "Normal" changes in vision

1.3 How the eye functions

1.4 Definitions

1.4.1 Visual impairment

1.4.2 Low Vision

1.4.3 Legal blindness

1.5 Leading causes of visual impairment

1.5.1 Cataracts

1.5.2 Glaucoma

1.5.3 Macular degeneration

1.5.4 diabetic retinopathy

1.6 Functional implications of diseases

1.7 Low vision aids

1.7.1 low vision clinics

1.8 Environmental modifications

Assignment - contrast

II. Walking in a familiar environment

2.1 Definitions

Orientation

Mobility

2.2 Travel Aids

2.2.1 human guide

2.2.2 dog guide

2.2.3 electronic aide

2.2.4 long care

2.3 Walking with a human guide

Position

Negotiating narrow spaces

Negotiating stairs

Going through doors

2.4 Seating

2.5 Entering/leaving an automobile

2.6 Walking without a guide

Trailing

Protective techniques

Sound localization

2.7 Room familiarization

III. Communication skills/aids -

Low vision writing aids

Telephone

Cassette

Time pieces

Contrast/large print

V. Community resources-

VI. Eating skills

RK/lb
6/89

A TRAINING MODEL TO TEACH COMMUNITY OUTREACH WORKERS TO TRAIN ELDERLY BLIND AND VISUALLY IMPAIRED AMERICAN INDIANS INDEPENDENT LIVING SKILLS: FOCUS ON FAMILY REHABILITATION

CHR FOLLOW-UP INTERVIEW

Reservation Visits

May 21-25, 1990

The following questions were used to structure interviews with CHRs who participated in the AFB training.

1. Describe the composition of your caseload
   children
   elderly, etc.

2. In what settings do you see clients?

3. How many clients are in your caseload?
   individuals and/or families

4. Were you aware of blind or visually impaired clients in your caseload before you came to the training session?
   During the training session?
   By the completion of the training session?

5. After the training, were you able to identify visually impaired clients in your caseload whom you had not previously identified?
   Immediately after you returned to work?
   Over time?

6. How many visually impaired clients have you identified since the training?
   How would you describe their functioning? (Physical, psychological)
   Do they have any other disability or health condition?

7. Have you been able to help a blind or visually impaired client by sharing information or skills learned in the training?

8. Have you been able to also share with family members?

9. What would you say has been more important -- the information you learned or the skills you learned?

10. Have you been able to improve the safety of a blind or visually impaired client?

11. Which skills have been most helpful to your client(s)?

12. In general, which skills do you feel are most helpful for you to know, for your clients, for the type of population you serve?

Communication Skills
- Telephone dialing
- Telling time
- Low vision materials
- Using a signature guide

Personal Management
- Money identification

Personal Grooming
- Shaving
- Applying toothpaste to toothbrush
- Applying lipstick

Clothing Care
- Clothing identification
- Clothing organization

Using Adaptive Sewing Items

Eating Skills
- Place setting
- Cutting food
- Using salt and pepper
- Spreading

Household Management
- Cleaning
- Identifying household and personal items
- Labeling

Kitchen Safety
- Pouring liquids
- Cutting and paring

Environment for Contrast

These questions are important follow-up information because they help us to know what to emphasize in further teachings, what information to eliminate in the curriculum and what information can be considered optional.

13. Do you remember the sighted guide technique?
Can you demonstrate it to me?
Have you taught it to anyone?
Is it something you think a visually impaired client would find useful? feel comfortable using? teach to others?

14. How would you describe family members' reactions to your instruction with a blind or visually impaired client?
Has teaching them skills helped their response?

15. Do you know the closest agency for the blind in your region?
Have you had any contact with the agency?
Prior to the training?

Since the training?
If so, how would you evaluate the assistance you and/or your client received?

16. Have you used or distributed any of the adapted equipment we distributed at the training session, such as hi-marks?

17. Do you remember the component of the training about the psychosocial adjustment to vision loss?
Was that information useful to you?

18. We are interested in knowing whether or not visual impairment interferes with the American Indian's participation in traditional activities, cultural events, religious celebrations.
Can you tell me what you think from your experience?
Can you describe a situation?
Was the curriculum model on adapted leisure activity useful to you?

19. Do you ever refer to any of the reading materials provided during the training?
Where are your reading materials kept?
Do others have access to them?

20. What happened when you returned to your work after the week-long training session?
Did your supervisor inquire about the training?
Did any of your co-workers?
Did you share information with others where you work?
How did you share that information -- make a written report, make a presentation at a staff meeting, provide in-service training, participate in a health fair?

21. Would you say that the training is something you use regularly or is information stored for future reference?

22. What can you say about the training that I can share with others around the country?

Members of the National Advisory Committee to the American Indian Project

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Steve Wilson, Chairperson, Oklahoma Indian Council on Aging, Elderly Program of the Creek Nation

Nicky Solomon, Director, Community Health Representative Program, Indian Health Service

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Security
Rehabilitation Services Admin.
Services for the Blind and
Visually Impaired
10 East Broadway, Suite 400
Tucson, AZ 85701

Linda Mock - Rehab. Coord.
Mary Boomer - Rehab. Teacher
Claude Garvin - Rehab. Teacher
Commission for the Blind
535 S.E. 12th Avenue
Portland, OR 97214

Philip McKinney, O.D.
Good Samaritan Hospital and
Medical Center
Devers Eye Institute
1040 N.W. 22nd Avenue
Portland, OR 97210

Project Tribal and State Representation

During the course of the project, the American Foundation for the Blind has trained community health representatives from the following tribes.

Apache of Oklahoma
Arapaho Tribe of Oklahoma
Blackfeet Tribe of Montana
CRIT
Caddo Tribe of Oklahoma
Cherokee Tribe of Oklahoma
Chickasaw Nation of Oklahoma
Chippewa Tribe of Minnesota
Chitimacha of Louisiana
Choctaw Tribe of Oklahoma
Coeurdalene
Colinelle
Comanche Tribe of Oklahoma
Confederated Tribes of Warm Springs, Washington
Coushatta Tribe of Louisiana
Creek Nation of Oklahoma
Delaware Tribe of Oklahoma
Eastern Band of Cherokee, North Carolina
Fort Hill Apache
Fort Sill Apache of Oklahoma
Havasupai
Hopi
Hualapai
Jicarilla Apache
Kaibab-Paiute
Kickapoo Tribe of Oklahoma
Lummi
Miami Tribe of Oklahoma
Miccosukee Seminole of Florida
Mohawk
Nambe Pueblo
Navajo Nation of Arizona
Navajo Nation of New Mexico
Nez Peroe Tribe of Idaho
Nooksak Tribe of Washington
Northern Cheyenne
Ohama
Oneida
Osage Tribe of Oklahoma
Paiute
Papago Tribe of Arizona
Pascua/Zaui
Passamaquoddy Tribe of Maine
Penobscot
Pequot Tribe of Connecticut
Picuris Pueblo
Pima Maricopa

Pueblo of Acoma
Pueblo of Isleta
Quechan
Quinault
Rosebud Sioux
Sac and Fox of Oklahoma
San Carlos Apache of Arizona
San Felip Pueblo
San Ildefonson Pueblo
San Juan Pueblo
Santa Ana Pueblo
Santa Clara Pueblo
Santee
Santo Domingo Pueblo
Sells of Arizona
Seminole of Oklahoma
Seneca Nation of New York
Shawnee Tribe of Oklahoma
Shoshone Bannock
Sioux Tribe of South Dakota
Southern Ute of Colorado
Taos Pueblo
Tesque Pueblo
Tohono O'odham
Umatilla Tribe of Oregon
Ute Mountain Ute
Wichita Tribe of Oklahoma
Winnebago
Yakima Indian Tribe of Washington
Zia Pueblo
Zuni Pueblo of New Mexico

Community Health Representatives represented the following twenty-seven states.

Alabama
Alaska
Arizona
California
Colorado
Connecticut
Florida
Idaho
Iowa
Louisiana
Maine
Michigan
Minnesota
Mississippi
Montana
Nebraska

Nevada
New Mexico
New York
North Carolina
North Dakota
Oklahoma
Oregon
South Dakota
Tennessee
Washington
Wisconsin

Professionals Certified by the American Foundation for the Blind to Teach the 5-Day Specialty Training on Aging and Vision Loss and Independent Living Skills Training

Myrtle A. Patterson
514 East Tyler
Stillwater, Oklahoma 74075
918-762-2517

P. J. Overholtzer
P. O. Box 90608
Anchorage, Alaska 99509
907-333-3406 or 248-6937

Vondelear Haggins
10204 Avenida Serena N.W.
Albuquerque, New Mexico 87114
505-897-0194

Madonna Beard
HCR 89, Box 203
Hermosa, South Dakota 57744
605-255-4239 (home)
605-348-2677 (work)

Cheryl LaPointe
CHR Program - IHS
Room 6A-54
Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20852
301-443-2500

Professionals Certified to Teach the 4-Hour Component on Aging and Vision Loss Incorporated into CHR Basic Training

Corinne Axelrod
California Rural Indian Health Board
2020 Hurley Way, #155
Sacramento, California 95825
916-929-9761

George H. Lomayesva*
7900 South J. Stock Road
Tucson, Arizona 85746
602-629-5232, ext. 6751

*To be certified for specialty training in 1991.

DEPARTMENT OF HEALTH & HUMAN SERVICES
PUBLIC HEALTH SERVICE

July 21, 1989

ALASKA AREA NATIVE HEALTH SERVICE
250 GAMBELL STREET
ANCHORAGE ALASKA 99501

Refer to: A-CHAP

RECEIVED
JUL 28 1989

Alberta Orr
Project Director
American Foundation for the Blind
15 W. 16th Street
New York, N.Y. 10011

Dear Alberta:

In follow-up to our telephone conversation of July 7, 1989 I want to keep you informed of progress in recruiting 20-25 students for an autumn class in Alaska.

Enclosed is a memo that is going out to supervisors of both Community Health Representatives and Community Health Aid/Practitioners in Alaska. It is also going to the Clinical Directors of the regional hospitals, who may have assistants in the Eye Departments or other outreach workers who could use these skills, and Regional Health Directors.

I have asked for nominations by August 1, 1989. I have also announced this request on conference calls to the CHR Coordinators. As I informed you on the phone, getting nominations for other training has been difficult this year in Alaska. Our CHR Coordinators are addressing this problem now as part of their newly-organized committee, and I should have more specific numbers by August 1.

Your proposed training dates in August are most difficult for the Alaska CHRs this year. I wish to request that this training take place in November instead. This is the consensus of the CHR Coordinators committee and I concur with their request for these reasons: We will be having a 3 week Basic Training class in mid August to September 1, 1989 for 30 students, and a specialty training conference the first week in September for up to 60 students. Both would draw from the same pool of potential students for your class.

By early November, the subsistence activities will have tapered down and the drain on CHR/CHA resources by the cleanup efforts of the Exxon oil-spill will have subsided for the winter. We will then be more likely to find students willing and able to attend this class.

Alberta Orr, Project Director
July 20, 1989

Please keep me informed of your progress in determining class dates and location. I will respond with an estimate of student numbers as soon as I can. I am also attaching a summary of Alaska Area Statistics for the year 1989 (on eye diseases and diabetes) to help you in focusing your content and assessing the potential impact of training.

Your program comes highly recommended and the Alaska Area will work to find students who will use these valuable skills in rural communities and villages.

Sincerely,

Dorothy Wambolt, FNP
CHR Training Coordinator

cc: Nicky Solomon
Cheryl LaPointe
A-D
Training Committee Members
CHR Reading File

Enclosure
Course Announcement
Overview of Alaska Area Statistics for Eye Disease
Number of Visually Impaired Eskimos

UNITED STATES GOVERNMENT

memorandum

DATE: July 17, 1989

REPLY TO ATTN OF: Chief, A-CHAP

SUBJECT: Course Announcement - Student Recruitment

TO: CHR Coordinators
CHAP Directors
CHA Coordinator Instructors
Clinical Directors, Service Unit Hospitals

Dear Supervisor:

This fall, the American Federation for the Blind will be offering a course in Anchorage "Training Community Outreach Workers Independent Living Skills: Focus on Elderly Blind and Visually Impaired American Indians."

The goal is for village workers to be able to teach visually impaired elders self-help skills. Course content will include information on aging, vision and causes of visual impairment, and independent living skills.

This highly-rated course is being offered in Alaska for the first time. For the elderly with visual impairment, these skills may make it possible to remain in the village, maintaining relative independence, and avoiding unnecessary illness and injury.

Please nominate any of your employees who would be likely to use this skill in their communities. The class is limited to 20. Dates are yet to be determined, estimated early November, for 5 days. For more details please call Dorothy Wambolt or Lucille Davis at Alaska Area Office, 257-1302 by August 1, 1989.

Dorothy Wambolt

Dorothy Wambolt
Ak Area CHR Training Coordinator

Concur: Jimmie Williams

cc: Nicky Soloman, CHR Director
Alberta Orr, Project Director AFB
Area Director

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114

U.S. GPO: 1989-241-375 80109

UNITED STATES GOVERNMENT

memorandum

DATE: July 17, 1989

REPLY TO ATTN OF: Chief of Ophthalmology, ANMC

SUBJECT: Number of Visually Impaired Eskimos

TO: Dorothy Wambolt,
Area CHAP Program

As per our conversation, our most recent survey of etiology of blindness among Alaska Eskimos is the *survey done among the Norton Sound and Bering Strait region. This survey was done by G. H. M. B. Van Rens in 1985 to 1986. In this region, approximately 1677 natives were examined, and of this, the incidence of bilateral blindness was 0.6% or 8 patients. Predominant cause of blindness in this group, representing over 62% of cases, was macular degeneration. Corneal scarring represented another 2 patients, and Glaucoma 1 patient for a total of 8. This total incidence of blindness is representative of approximately 15 villages covered within the study. As you can see, the incidence of blindness per village is remarkably low. It is also of note that the cause of preventable blindness is usually considered to be cataract or other infectious etiology, which is negligible in this study.

My suggestion for your training would be to employ those most commonly associated with the treatment of and the care for patients with eye disease. When this subject was broached two years ago with the original plan, the eye Secretary as well as the Eye Nurse were both interested in the training program. If you would like me to contact the various optometry programs in the Bush in regard to training of selected members of their staff in the care and education of blind adults, I will be glad to do this for you. If I may provide you with further information on the incidence of blindness in the Alaska Area, please call.

Robert P. Werner, M.D.

* Ophthalmologic Findings Among Alaskan Eskimos of of the Norton Sound and Bering Straits Region, by G. H. M. B. Van Rens, pub. 1988

OPTIONAL FORM NO. 10
(REV. 1-80)
GSA FPMR (41 CFR) 101-11.6
5010-114

U.S. Government Printing Office 1980—341-526/6193

OVERVIEW OF ALASKA AREA STATISTICS FOR EYE DISEASES

Sources: AANHS " Leading Health Problems ", FY1987,Patient Care Standards Branch; Alaska Diabetics Major Complications, 1/86 to 5/89, chart review, Alaska Area Diabetes Program.

For the entire Alaska Area in the fiscal year 1987, eye diseases ranked tenth in the 23 causes of number of hospital days, but was not in the top 15 of 23 causes for diagnoses at discharge. Eye diseases accounted for 1.8% of the total hospital diagnoses at discharge, with 185 patients out of a total of 10,246 for all area hospitals, broken down this way:

Catarracts:	102
Glaucoma:	14
"Other":	69

Blindness was not included in the diagnoses.

For Alaska Area outpatient visits in 1987, the only eye-related problem listed in the top 15 of 23 diagnoses was for refractive error. Total eye diseases accounted for 17,489 visits, 4% of a total of 433,632 outpatient visits. Of these, the diagnoses most often reported were:

Refractive Error:	7901
Conjunctivitis:	3960
Inflammatory Diseases:	1178
"Other":	3850

There was no differentiation in the type of condition for which refractive correction was sought. These numbers reflect total visits, not first time diagnoses only. Multiple visits by the same patient have not been selected out for either hospitalization or outpatient data.

Diabetes Program Data:

Preliminary chart reviews from the diabetes program were done by Dr. Cindy Schraer, who directs the Alaska Area Diabetes Program, to identify the number of patients and visits for the major complications of diabetes, including blindness. Data collected from 1/86 through 5/89 show 15 total visits where legal blindness was entered on the problem list. This identified 15 separate patients, but did not include patients for whom their blindness was not a contributing factor to the visit or hospitalization. These numbers also did not necessarily indicate new diagnoses. The reasons for their visual impairment were not stated, but when they were also diabetic, this was coded. Retinopathy was diagnosed in 80 separate patients, although this review did not include all the possible retinopathy patients as some codes were purposefully excluded. One patient with retinopathy had catarracts, and two with retinopathy had undergone laser surgery. None of the legally blind patients had a diagnosis of diabetes.

Impressions from the Opthalmology Department

Dr. Robert Werner, Chief of the Opthalmology Department at the Alaska Native Medical Center estimates that in some villages there may be no more than one legally blind patient, and in many there are none with significant visual impairment. New cases of blindness in Alaskan Natives are evaluated here at the Anchorage hospital, and patients then referred to the Louise Rude Center here, where a similar kind of training to yours takes place. Dr. Werner's opinion is that there are very few new cases of blindness each year in Alaska. Most natives with visual impairment that have had it a long time, have already adapted to their situation and learned many of these skills. He felt that most directly helpful services are provided to blind patients by workers at the seven regional hospitals, who work directly and most frequently with these patients. These regional folks could benefit greatly by your program. He will be recruiting names for me for the class from the Service Unit Hospitals, and has summarized two prevalence studies on blindness done in two of the regions of this state. (see attached letter).

In summary, these facts appear to indicate that visual-impairment is not yet a significant problem for any native group in Alaska, even with the elderly in the villages. Certainly it does not indicate a critical training need that has gone unmet by current resources. I hope this information is helpful to you in planning for the Anchorage class. I have certainly learned a great deal in gathering this information, as it has confirmed our initial impressions. As I receive additional relevant material, I'll send it on to you.

cc: Nicky Solomon, National CHR Director
Cheryl La Pointe, CHR Program Analyst, Headquarters
G. Ivey, Alaska Area Director
James Berner, M.D., Chief, A-CHSB
Thomas Goldston, Chairman, Alaska CHR Training Subcommittee
Cindy Schraer, M.D., Director, Alaska Area Diabetes Program
Robert Werner, M.D., Chief, Opthalmology, ANMC
Frank Williams, Chief, A-CHAP

A TRAINING MODEL TO TEACH COMMUNITY OUTREACH WORKERS TO TRAIN ELDERLY BLIND AND VISUALLY IMPAIRED AMERICAN INDIANS INDEPENDENT LIVING SKILLS: FOCUS ON FAMILY REHABILITATION

Dissemination Paper

During the project period the following dissemination activities were carried out to inform the aging, blindness and Indian health system about the goals and scope of the rehabilitation project.

Presentations

"American Foundation for the Blind CHR Program Training Initiative," presented at the Indian Health Service Community Health Representative Program, Joint IHS/Tribal Representative Meeting at the third Triennial Meeting of the National Association of Community Health Representatives, Las Vegas, Nevada, March 27-April 2, 1988.

"A Training Model to Reach a Hard-to-Reach Elderly Blind and Visually Impaired Population: The Case of the Elderly Native American," presented at the Biennial International Conference of the Association for Education and Rehabilitation of the Blind and Visually Impaired, Montreal, Canada, July 10-14, 1988.

"A Model Curriculum to Teach American Indian Health Care Workers Independent Living Skills to Assist Blind and Visually Impaired Elders," presented at the Biennial International Conference of the Association for Education and Rehabilitation of the Blind and Visually Impaired, Montreal, Canada, July 10-14, 1988.

"Teaching Indigenous Community Outreach Workers to Teach Blind and Visually Impaired American Indians Independent Living Skills," presented at the annual meeting of the National Association of Area Agencies on Aging (NAAAA), New Orleans, Louisiana, July 25-26, 1988.

"A Training Model to Teach Community Outreach Workers to Train Elderly Blind and Visually Impaired American Indians Independent Living Skills," presented at the annual meeting of the Southwest Society on Aging, Tulsa, Oklahoma, September 18-21, 1988.

"A Training Curriculum to Teach Indian Health Service Workers to Teach Blind and Visually Impaired American Indian Elders Independent Living Skills," presented at the National Conference on Native Americans with Disabilities, sponsored by the American Indian Rehabilitation Research and Training Center, Northern Arizona University, Denver, Colorado, September 22-24, 1989.

"Teaching Blind and Visually Impaired American Indian Elders Independent Living Skills," presented at the Annual Meeting of the National Council on Aging, New Orleans, Louisiana, March 29-April 1, 1989.

"A Training Model to Teach Visually Impaired American Indians Independent Living Skills," presented at the 35th annual meeting of the American Society on Aging, Washington, D.C., March 18-21, 1989.

"A Culturally Relevant Model Curriculum on Aging and Vision Loss for Use in Training Indigenous Health Care Personnel to Work with Elderly Blind and Visually Impaired American Indians," presented at the Sixteenth Annual Meeting of the Association for Gerontology in Higher Education, Kansas City, Missouri, March 1-4, 1990.

"Models for Reaching Older Blind and Visually Impaired People: The American Indian Elder," presented at the Biennial International Conference of the Association for Education and Rehabilitation of the Blind and Visually Impaired, Washington, D.C., July 21-25, 1990.

Publications

"Training Program to Help Blind Native American Elderly," in AFB NEWS, July-September 1988.

"AFB Professional and Public Education Efforts Target Diabetes and Visual Impairments," in AFB NEWS, July-October 1989.

"The American Indian Rehabilitation Project for Blind and Visually Impaired Elders," disseminated to the State Units on Aging for dissemination to Area Agencies on Aging, February 1988.

"Project Abstract" disseminated to 300 rehabilitation agencies for the blind in the United States, December 1988.

Press Release

NEWS, American Foundation for the Blind, "AFB Launches Program to Assist Elderly Blind and Visually Impaired American Indians," January 22, 1988.

Television News Coverage

NBC's KVOA-TV in Tucson featured coverage of the AFB "Train the Trainers" session in Tucson, Arizona on the 5 p.m. edition of the evening news on August 4, 1989.

Dissemination activities resulted in inquiries about the Community Health Representative Training Program from as far as the South African National Council on the Blind. These inquiries originated out of the need for similar trainings in areas which have not had the opportunity to develop methods to reach the "hard-to-reach" client population.

Future Dissemination Activities

Article will be prepared for the Journal of Visual Impairment and Blindness, the professional journal in the field of blindness published by the American Foundation for the Blind.

Article will be submitted to the Gerontologist, journal of the Gerontological Society of America.

Article will be submitted to Minority Aging Exchange.

Article will be submitted to AGING, the publication of the Administration on Aging.

Project Executive Summary will be disseminated to:

- agencies for the blind and visually impaired throughout the country
- members of State Units on Aging
- national Indian organizations
- The Indian Health Service
- the CHR area coordinators

Training Program to Help Blind Native American Elderly

During the daily living module, trainees learn spreading and cutting eating techniques while under a blindfold.

By Fay Hava Jarosh

Native American health care service workers will bring a new knowledge about blindness and visual impairment to the communities they serve, and the blindness field will benefit from new perspectives on working with diverse American cultures—thanks to a unique grant program being funded by the U.S. Administration on Aging.

The project was established by AFB to train 200 Native American Community Health Representatives to teach independent living skills to elderly visually impaired Native Americans.

Community Health Representatives, employees of the federally sponsored Indian Health Service program, work with Native American elderly people in a wide range of health care settings on their reservations and in the community.

The AFB grant program resulted, in part, from earlier efforts by AFB's Southwest and Western regional centers to forge a network between blindness agencies and the Native American social service delivery system. (For related articles, see AFB NEWS, Fall 1986 and AFB NEWS, Fall/Winter 1987.)

"Diabetes is a number one health problem in Native American communities, with a correspondingly high rate of blindness and visual impairment," said Nicky Solomon, national director of the Community Health Representatives (CHRs) program. "But limited resources and severe fiscal cuts make it difficult for us to provide comprehensive training and education programs for CHRs in this area." She noted that more than 350 CHRs responded to the initial call for 200 trainees for the AFB program.

From December 1987 to August 1988, one-week educational seminars were conducted in Oklahoma, New Mexico, California, and North Dakota. The training program included presentations on blindness, low vision, and eye diseases; sighted guide techniques; daily living skills; the role of the family in rehabilitation training; psychological aspects of aging and vision loss, and screenings of various AFB educational films.

Serving as the rehabilitation teacher at these training sessions was Ruth Kaarlela, who recently retired as chairperson of the department of blind rehabilitation at Western Michigan University.

Community Health Representatives practice using a check writing guide and other writing and communication aids.

AFB's national consultants on aging Alberta L. Orr and Jamie Casabianca-Hilton, who are project director and director of training for the project, respectively, said, they, too, have learned new things.

"The CHRs represent American Indian tribes from Maine to Florida and Alaska to Southern California, all with diverse languages and cultural beliefs," said Casabianca-Hilton. "We discovered that what is culturally appropriate for one group is not necessarily appropriate for another." She noted that trainers often had to modify components of the program for each training site.

For example, the section on low vision which emphasizes the use of good lighting in the home proved irrelevant to CHRs working with elderly visually impaired Native Americans who live on reservations without electricity.

Orr noted the differences in Native American attitudes about blindness. Among certain tribes, greater emphasis is placed on acceptance of blindness as one's life condition, rather than the expression of feelings of loss or efforts for adjustment.

Tribal Politics

And, according to Orr, tribal politics set the standard for a particular line of thinking and actions. "In order to make the greatest impact on the visually impaired person and his family, it is important to also educate tribal leaders about blindness," she said. "The CHR's success in this capacity will ultimately be determined by their political position on the reservation."

Based on their experience in working with diverse Native American cultures, Orr and Casabianca-Hilton intend to refine the model teaching curriculum for dissemination to organizations and agencies on aging and blindness as well as to national Native American organizations.

Discussions are currently under way to extend the program. An extension, the grant administrators say, will enable them to respond to the demand for more training sessions as well as integrate curriculum content on aging and vision loss into other educational programs offered by the Indian Health Service.

Fitness Conference for Blind People

DALLAS—AFB's Southwest Regional Center reported excellent attendance at a health and fitness conference for blind and visually impaired people in Dallas May 7. The conference was co-sponsored by AFB's Southwest Regional Advisory Board and the Institute for Aerobics Research, founded by Dr. Kenneth Cooper. It featured presentations by Dr. Cooper, author of Aerobics Program for Total Well-Being, and Harry Cordelles, a marathon runner who is blind, who served as honorary chairman of the conference.

Brian Padden of Richardson, TX, observes his 15-year-old son, Chris, during a brief workout at the health & fitness conference for blind and visually impaired people held at the Institute for Aerobic Research in Dallas.

Low Vision Workshop Held in Montana

BILLINGS, MT—More than 125 parents, educators, rehabilitation personnel and eye care professionals attended a low vision workshop held in Billings, MT, May 19-21, according to AFB's Southwest regional director Judy Scott.

Scott and Gayle Watson of the Pennsylvania College of Optometry made a presentation on "The Visually Handicapped Child," and Leslye Piqueras, AFB's national consultant in low vision, discussed "Futuristic Aspects of Low Vision."

The conference, which Scott helped organize, was co-sponsored by the Southwest Regional Center and other agencies and organizations offering services to blind people in Montana.

AFB INVITES NOMINATIONS FOR BEST NARRATORS OF TALKING BOOKS

NEW YORK—AFB is inviting nominations for the 1988 Alexander Scourby Narrator of the Year Award and the Talking Book Hall of Fame.

The Alexander Scourby Award was established in 1986 by AFB in memory of its most popular Talking Book narrator, and the Talking Book Hall of Fame is being established this year to recognize significant lifetime achievement in the narration of Talking Books for blind, visually impaired and physically handicapped people.

All Talking Book readers are eligible to nominate a Talking Book narrator for each award—the Alexander Scourby Narrator of the Year Award and the Talking Book Hall of Fame—which will be presented in December in New York.

To receive a braille/print nominating ballot for the awards, call AFB's toll-free hotline 1-800-232-5463 (New York residents call 212-620-2147). Or, write the name of one narrator for each award on your own ballot and submit it to: American Foundation for the Blind, Department PR, 15 West 16th Street, New York, NY 10011. Nominations must be postmarked no later than October 15, 1988.

Previous recipients are not eligible for the Alexander Scourby Narrator of the Year Award, which was won in 1986 by Bob Askey of Longmont, CO, and in 1987 by Merwin Smith of Denver.

AFB records Talking Books for the National Library Service for the Blind and Physically Handicapped, which administers the program. Anyone in America with a visual or physical disability that prevents reading of conventional print materials is eligible to receive Talking Books and special playback machines free of charge from 160 regional libraries throughout the United States.

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AFB's Professional and Public Education

By Terry Allen

November is National Diabetes Month, established to heighten awareness of one of the nation's most troubling, but often overlooked, health problems. The American Diabetes Association reports approximately 11 million Americans have the disease and, unfortunately, half of them don't know it. Diabetes, a metabolic disorder that affects the way the body uses food, is also the leading cause of blindness and visual impairment in the United States. More than 5,000 new cases of blindness will be reported this year as a result of diabetic retinopathy, a disease that damages the blood vessels in the back of the eye. When these blood vessels are damaged, the eye can no longer send a clear picture to the brain. Early detection and treatment of diabetes is crucial to the prevention of blindness or serious visual impairment. For even when diabetic symptoms go unnoticed, damage to the retinas occurs.

Florida Model Task Force on Diabetic Retinopathy

In 1987, a Florida ophthalmologist, frustrated in her attempts to coordinate diabetes and vision loss programs in her area, contacted AFB's Southeast Regional Center in Atlanta to voice her concerns. Regional director Gerda Groff and regional specialist in aging Oraien Catledge investigated the physician's concerns and shared them with staff of the Florida Division of Blind Services and the diabetes consultant of the Florida Health and Rehabilitative Services Chronic Disease Control Unit. All agreed that inadequate education among medical professionals, people with diabetes, and the general public about diabetic retinopathy was indeed a problem.

To combat this problem, AFB pledged $7,500 in start up funds and staff services with the provision that any programs developed be documented for use as a national model. This initiative became the Florida Model Task Force on Diabetic Retinopathy and drew members from over 30 groups involved with blindness and or diabetes. Coordination of the task force was undertaken by the Florida affiliate of the American Diabetes Association (ADA) as a special project to run from January 1988 until July 1989.

According to Groff, the task force's mission was "to reduce visual impairment and blindness resulting from diabetic retinopathy and to establish awareness of diabetic retinopathy as a major health problem." To do this, the task force adopted the ADA committee structure and established, among others, committees to handle public education, patient education, professional education, and public relations.

The accomplishments of the task force have been noteworthy. Among them:

- Compilation of a "Resource Directory" listing information on all public and private agencies in Florida that provide health care, social or economic assistance.
- Preparation of an informational brochure, "Diabetes and Blindness," which outlines symptoms, diagnostic techniques, and potential treatments for diabetic retinopathy. The brochure was distributed throughout the state in both English and Spanish.
- Development of continuing education programs to ensure that all health care professionals caring for a diabetic patient are aware of the potential for eye complications and know where to turn for services.
- Endorsement by U.S. Senator Lawton Chiles (D-FL), serving as honorary chairman of the task force. Sen. Chiles brought media coverage to special public awareness programs, such as eye screening projects, and participated in radio and television public service announcements to encourage high risk individuals to have periodic eye exams.

"The data currently available is beginning to reflect the impact of the task force," says Catledge, "and indicates that original projections were correct. The Division of Blind Services registration of people with diabetic retinopathy has doubled in the year since the task force began work."

Adds Groff, "Though the initial objectives of the task force have been met, the continued development of a strong network of agencies in Florida will require that task force members continue to work closely together."

A detailed article by Groff, fellow task force member Boe Barrett, and chairperson Priscilla Rogers on the formation and activities of the task force has been accepted for publication in an upcoming edition of AFB's *Journal of Visual Impairment & Blindness*. An information kit prepared by the task force is available by writing Priscilla Rogers, Division of Blind Services, 2540 Executive Center Circle West, Tallahassee, FL 32399.

Native Americans

Diabetes is a particularly major health problem in the Native American community. In fact, a recent American Indian Health Care Association study among urban Native Americans in Arizona found diabetes to be epidemic. Compared to a U.S. prevalence of 3.4%, 11% of urban Native Americans have diabetes. Further, family history of diabetes, one of the most important factors associated with increased risk for developing the disease, was found in 38.5% of those studied. It is therefore no surprise that Native Americans have a correspondingly high rate of blindness and visual impairment. And there is a critical backlog of cases of Native Americans needing vision services.

An AFB-sponsored training program uses simulation exercises to train Native American health care workers to teach independent living techniques to visually impaired Native Americans.

In 1987, AFB obtained a $200,000 grant from the U.S. Administration on Aging to establish a 17-month project to address these concerns (see *AFB NEWS, July/September 1988*). Project director Alberta L. Orr and Jamie Casabianca Hilton, AFB's national consultants on aging, along with Ruth Kaarlela, Ph.D., a rehabilitation teacher and retired chairperson of the Department of Blind Rehabilitation and Mobility at Western Michigan University in Kalamazoo, conducted week-long workshops for Native American health care workers, participants in the Indian Health Service's Community Health Representatives (CHRs) program. CHRs work with elderly blind and visually impaired people on and off reservations.

The sessions, which were conducted in Oklahoma, New Mexico, California, and North Dakota, included presentations on blindness, low vision and eye diseases, sighted guide techniques, daily living skills, the role of the family in rehabilitation training, adapted recreation, and the psychosocial aspects of aging and vision loss.

"The goal of the program is to train people who serve as community outreach workers to teach independent living techniques to elderly visually impaired Native Americans," says Orr.

To ensure that this unique and successful program continues, AFB received a supplemental grant from the Administration on Aging to conduct a two-week "Train the Trainers" session. Held in Tucson, AZ, in August 1989, eight health educators representing tribes in different regions of the country participated. They, in turn, will provide training for CHRs in their geographic areas. In addition, elements of the AFB program will be incorporated into the training given to all future CHRs.

Nationwide Efforts

For many years AFB has made specially adapted products available to blind and visually impaired people with diabetes through the *Products for People with Vision Problems* catalog. These include special syringes and filling or guiding devices designed to assure delivery of an accurate dose of insulin.

Most recently, engineers in AFB's National Technology Center developed Touch n Talk®, a synthetic speech output box that enunciates the messages shown on the LifeScan One Touch® Blood Glucose Monitoring System. This enables a visually impaired person to accurately monitor blood glucose levels independently.

In 1988, AFB made additional services available to visually impaired people with diabetes through the National Task Force on Diabetes and Visual Impairment. The group, comprised of diabetes educators, physicians and nurses, and blindness professionals, shared resources about vision loss associated with diabetes and evaluated consumer products.

As part of this group's efforts, AFB distributed a self-help diabetes management program on audiocassettes. The two-tape set, entitled *Managing Your Diabetes with Vision Impairment* and *American Diabetes Association American*

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